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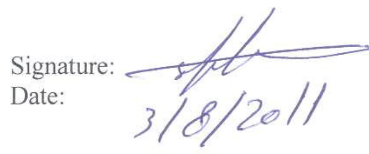

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الجامعة الأردنيـة
كلية الدراسات العليا

نموذج رقم (١٦)
إقرار والتزام بالمعايير الأخلاقية والأمانة العلمية
وقوانين الجامعة الأردنية وأنظمتها لطلبة الماجستير

أنا الطالب: سامي زعل فلاح الشناق الرقم الجامعي: ٩٠٥٠٣٠٧
التخصص: دكتوراه تربية الكلية: التربية

عنوان الرسالة / الاطروحة
Psychosocial Correlates of Childhood Experience of Abuse Among University Students In Jordan

أعلن بأنني قد التزمت بقوانين الجامعة الأردنية وأنظمتها وتعليماتها وقراراتها السارية المفعول المتعلقة باعداد رسائل الماجستير والدكتوراة عندما قمت شخصيا" باعداد رسالتي / اطروحتي ، وذلك بما ينسجم مع الأمانة العلمية المتعارف عليها في كتابة الرسائل والأطاريح العلمية. كما أنني أعلن بأن رسالتي /اطروحتي هذه غير منقولة أو مستلة من رسائل أو أطاريح أو كتب أو أبحاث أو أي منشورات علمية تم نشرها أو تخزينها في أي وسيلة اعلامية، وتأسيسا" على ما تقدم فإنني أتحمل المسؤولية بأنواعها كافة فيما لو تبين غير ذلك بما فيه حق مجلس العمداء في الجامعة الأردنية بالغاء قرار منحي الدرجة العلمية التي حصلت عليها وسحب شهادة التخرج مني بعد صدورها دون أن يكون لي أي حق في التظلم أو الاعتراض أو الطعن بأي صورة كانت في القرار الصادر عن مجلس العمداء بهذا الصدد.

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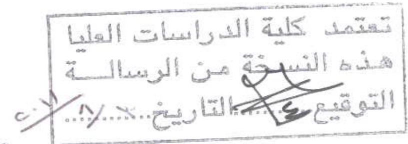
PSYCHOSOCIAL CORRELATES OF CHILDHOOD EXPERIENCE OF ABUSE AMONG UNIVERSITY STUDENTS IN JORDAN

By
Sami Shennaq

Supervisor
Dr. Ayman Hamdan Mansour

Co-Supervisor
Dr. Rose Costantino

This Dissertation is submitted in Partial Fulfillment of the Requirements for the Doctor of Philosophy Degree in Nursing Science.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COMMITTEE DECISION

This Dissertation (Psychosocial Correlates of Childhood Experience of Abuse among University Students in Jordan) was successfully Defended and Approved on 21/7/ 2011

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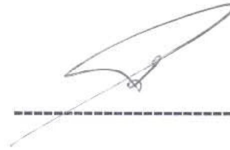
Dr. Muayyad Mustafa Ahmad **Associate Professor, Jordan University**	 ----------------------
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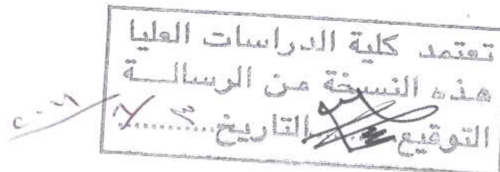

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Dedication

To my parents, who inspired and influenced me to be who I am today….I love you!

To my wife, for her endless support, patience, and love……I love you!

To my children Rashed, and Sara, for being in my life……I love you!

To my brothers and my sisters, for their support and encouragement. …..Thank you!

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ABSTRACT

Child abuse is a psychosocially devastating health problem for individuals, families and the society. Children who experience child abuse face psychosocial health disorders throughout their lifetime. The purpose of this study was to investigate the association between childhood experience of abuse and long term effects of psychosocial health disorders among Jordanian universities students. A cross-sectional study involving 1400 University students was conducted by using a self-reported questionnaire, from July to November 2010.

Results showed that of the 1400 students, 79.8% reported emotional abuse, 53.9% reported sexual abuse, and 27.9% reported physical abuse. Results also showed that childhood experience of abuse continue to exert long term effects of psychosocial health disorders among university students. Perceived social support from family and peers mediates both childhood experience of abuse and psychosocial health disorders. Male students with low household income, and living with a person other than one of their parents are more likely to report being abused than female students with satisfactory household income, and living with a parent or with one of them.

The results of the study also suggested that different forms of childhood experience of abuse may lead to different psychosocial health disorders among victims. Further studies are needed to enable better understanding of the psychosocial impacts on the individual life. Health care professionals, policy and decision makers in health and education systems are required to develop strategies to detect, report, and deal with abused children to ensure that they will be mentally healthy young adults. Certain procedures and interventions have to be considered to improve mental health of young adults. In particular, early detection of history of abuse will allow better intervention, and approach is to investigate the university students' psychological disturbances.

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CHAPTER ONE

1. Introduction

This chapter provides background information about the incidence and prevalence of child abuse and its impact on psychosocial heath status, problem statement, research questions, and significance of the study. Furthermore, this chapter presents the conceptual framework for the study, conceptual and operational definitions of both child abuse and psychosocial heath disorders.

1.1 Background

Child abuse is a horrific phenomenon in which children do not receive the protection, care, nurturance and interactions that are necessary ingredients to human development (Garaibeh & Hoeman, 2003). One child in every 58 children was a victim of child abuse in the United States (Sedlak, Mettenburg, Basena, Petta, McPherson, Greene, & Li. 2010). Recently, child abuse received increasing attention related to its prevalence and long term consequences (Back, Fitzgerald, Shaffer, Salstrom, & Osman. 2003).

The magnitude of child abuse in Jordan is increasing and according to the Department of Criminal Data at the Public Security Directorate, the total number of abused children increased from 295 cases in 1998, to 2.808 cases in 2006 (UNICEF, 2007). Child abuse issues received little attention to the Jordanian society due to cultural constraints, values, sensitivity and secrecy of topic. Also, the extent and severity of child abuse cases may remain underreported (Jordan River Child Safety, 2010).

In year 2008, Jordan witnessed a momentous milestone through existing law of protection of family from domestic violence; this law protects Jordanian families from abuse thus reducing the number of cases (Family Protection Department, 2010).

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Currently, Jordan is in the process of establishing child right law that enhances children's rights and protects them from harm and danger (National Council for Family Affairs, 2010).

The concept of child abuse has been influenced by the perspectives of various disciplines, and populations. Both concepts have been used interchangeably in the literature. National Child Protection Clearinghouse (NCPC, 2009) defines child maltreatment as “any non-accidental behavior by parents, caregivers, other adults or older adolescents that is outside the norms of conduct and entails a substantial risk of causing physical or emotional harm to a child or young person. Such behaviors may be intentional or unintentional and can include acts of omission (i.e., neglect) and commission (i.e., abuse)” (pp.1) (Bromfield, 2005; Price-Robertson & Bromfield, 2009). The definition provides a theoretical baseline to claim the interchangeable use and definition of abuse and maltreatment among children. Thus, child abuse and maltreatment are used in the literature within the same theoretical context. The prevalence of childhood abuse varies according to a number of factors including family characteristic, parents’ employment, socioeconomic status households, structure of family and living arrangement within the family. Moreover, other factors such as number of parents in the household and their relationship to the child, type of caregivers, family size, and perpetrator’s characteristics have been also play a significant role in childhood abuse occurrence (Sedlak et al., 2010).

Children who experience abuse are at very high risk in adulthood to experience of psychosocial and mental health disorders such as depressive symptoms, antisocial personality disorder, suicidal ideation and attempt, and substance abuse. Particularly, these psychosocial problems manifest and become symptomatic between age 16 and 25 years (Fergusson, Boden, & Horwood. 2008; Heffernan, Cloitre, Tardiff, Marzuk,

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Portera, & Leon. 2000). In addition, victims of childhood abuse have high rates of anxiety, eating disorders and post-traumatic stress disorder (McCloskey, & Walker, 2000; Widom, 1999).

The emotional and social development of abused children provides a compelling research question. Fergusson et al (2008) reported that abused children do often show unusual patterns of emotional development such as aggression, withdrawal and interpersonal disorder. The high level of stress associated with child abuse, especially sexual and physical abuse, can also lead to problems in mood and emotional stability such as depression and emotional distress (Grassi-Oliveira & Stein, 2008). As adults, victims of maltreatment and abuse during childhood have been found to report high rates of anxiety, anger, and physiological disturbances such as trouble sleeping, back pain, chest pain, and shortness of breath (Springer, Sheridan, Kuo, & Carnes. 2007). Attention should be given to the consequences of childhood experience of maltreatment and abuse in adulthood. The available information related to the prevalence of childhood abuse and its psychosocial impact in adults is emerging (Wilsnack, Wonderlich, Kristjanson, Vogeltanz-Holm, Richard, & Wilsnack. 2002).

The observed influence of social support on the health of individuals and society has evoked the attention of scientists from different disciplines. Despite the established connection between social support and a person's health, the relationship seems to be complex (Cohen, 2000). However, the quality of relationships among families and peers has been recognized as a good mediator of adolescents who are more prone abuse and psychosocial health disorders (Adams, William, & Bukowski. 2007).

The studies on the association between social support, childhood experience of abuse, and psychosocial health disorders among adolescent's revealed that childhood experience of abuse and psychosocial health disorders was related to the level of

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attachment with family and peers (Vranceanu, Hobfoll, & Johnson. 2007). Adolescents who reported stronger relationships with their families and higher number of friend are less likely to report psychosocial health disorders than those who have weak relationships with their families and fewer friendships (Powers, Ressler, & Bradley. 2009). The purpose of this study was to explore childhood experience of abuse and its psychosocial impact during adulthood among the Jordanian young adults, particularity university undergraduate students.

1.2. Problem statement

Childhood experience of abuse is disruption to the relations of the children in their family and society, which are the source of providing protection, care, and nurturance. Families are the primary contexts in which young children learn social behaviors, emotional maturity and create their value systems (Pollak & Tolley-Schell. 2004). In abusive families, children are exposed to maladaptive forms of emotional communication and behaviors and receive poor models of adaptive self-regulation, therefore; they are unable to meet their psychosocial and mental health needs (Pollak et al, 2004). The expected consequence is that abused children are more likely to experience mental, psychological and social deprivation that makes them vulnerable to a number of mental disorders later in life (Fergusson et al., 2008). Therefore, childhood experience of abuse has serious psychosocial consequences on individual wellbeing later on life.

There is a little information in the Jordanian literature about the long term impact of childhood experience of abuse. This study came to extend our knowledge and further to explore the long term psychosocial impacts of childhood experience of abuse. This study focuses on the impact of childhood experience of abuse among university students who are at a transition period of life that makes them at risk for a number of

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psychosocial disorders. This stage represents the transition period from childhood to adulthood in which individuals begin to develop social development. It is during this stage of development that most mental health problems start to appear (Kendall-Tackett, 2002). However, long term consequences of childhood experience of abuse in Jordan received little attention in the Jordanian literature. So socioeconomic factors such as poverty, malnutrition, and infections have significant contribution to childhood abuse and its impact may exacerbate the long term mental health consequences of abuse (Garaibeh and Hoeman, 2003). Therefore, the limited number of studies and lack of evidence-based data related to child abuse and its long term impact on adulthood merit attention and focus for further study. Moreover, the sequelae of child abuse in adults (if untreated) create many challenges for mental healthcare providers and policy makers who will have to rely on limited data-based information. Exploring such an important issue will enable better understanding of the problem, enhance evidence-based practice and may explain academic achievement and adaptation to the university life among university students. Therefore, the aim of this study was to investigate the association between childhood experience of abuse and psychosocial health disorders in a sample of Jordanian universities students.

1.3. Research questions are:

1. What are the forms of childhood experience of abuse among universities students in Jordan?
2. What are the relationships between childhood experience of abuse and psychosocial disorders (depression, stress, and sleep disturbance), and perceived social support among universities students in Jordan?

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3. What are the relationships between severity of childhood experience of abuse and psychosocial disorders (depression, stress, and sleep disturbance) among universities students in Jordan?
4. Are there differences in forms of childhood experience of abuse in relation to selected demographic and personal characteristics among universities students in Jordan?

1.4. Significance of the study

This study is addressed the long term impact of childhood experience of abuse on university students. This period of development is considered important in understanding the impact of childhood experiences, specifically, abuse and psychosocial health disorders. Jordan is witnessing rapid changes in legislation and policies on child abuse. Furthermore, the next few years may be significant in establishing reporting system for the prevention and management processes of child abuse (National Council for Family Affairs, 2010).

It is expected that findings of this study may enable mental health professionals, university officials and policy makers in mental health and educational system to better plan care for university-aged individuals. Furthermore, the results may represent an evidence-based knowledge regarding the impact of childhood experience of abuse on university-aged students and may enhance the correlates to the impact of abuse on the education and academic performance of this vulnerable group of population. Ultimately, findings of this study may provide a foundation for future studies, and contribute to the development of interventions designed to reduce the magnitude of childhood abuse occurrence and improve health status of victims of childhood abuse. Some participants of this study, as young adults will grow to become future decision- maker for prevention and management of child abuse issues.

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Particularly, this study is relevant to nurses in their ability to address issues of child abuse nursing care and decision-making, as well as the need to promote evidence-based nursing practice. Awareness of the multidimensional aspects of child abuse victims' health and their decision to seek healthcare is an essential element of nursing practice. This awareness puts nurses in a key position to explore, and recognize the possible influences of the victim's knowledge's, attitudes, and beliefs on their decision to disclose childhood experience of abuse and health and help-seeking behavior. The results of the study may enable nurses to engage in evidence-based practice and contribute to the development, coordination, and collaboration in the provision of health education programs or other intervention which aim to support and encourage victims of abuse in seeking healthcare as they cope with psychosocial problems.

An individual's response to experiences of abuse is affected by culture, values, and beliefs. Culture and tradition influence individuals' perceptions and response to abuse. Results of this study may provide new information that is useful for comparison across cultures and elicit additional exploration of cultural influences on perceptions and response students to childhood experience of abuse. Also, the results may encourage nurses and other health care professionals to include child abuse assessment in their health examination of children at inpatient and outpatient health care settings. Furthermore, this study stresses on importance of collaboration between health personnel, social workers, teachers, and families to overcome and disclose childhood abuse thus identifying cases of child abuse and providing support and care to the victims'

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1.5. Conceptual framework

A proposed framework of transactional model of appraisal, stress, and coping which was developed by Spaccarelli in 1994 (Figure 1) was used to guide the study. In addition, this study requires a framework that includes consideration of the choice of coping strategies for victims of child abuse. Spaccarelli (1994) devised a transactional model stressing the importance of appraisal, stress, coping and social support in helping the victim. It identified that the key issue in a victim of child abuse is in how they recognize a stressor, respond to it, and ultimately copes with it. Spaccarelli (1995) identified three psychological responses common in victims of child abuse, namely self-blame (whereby victims hold themselves to be responsible for the abuse they suffered, feeling shame and guilt); being suspicious and mistrustful of others as a result of the abuse (given that generally speaking the perpetrators are known or even related to the victims of child abuse); and fear of the affect the abuse would have on other relationships the victim has, such as feeling unworthy to have normal relationships after having been abused.

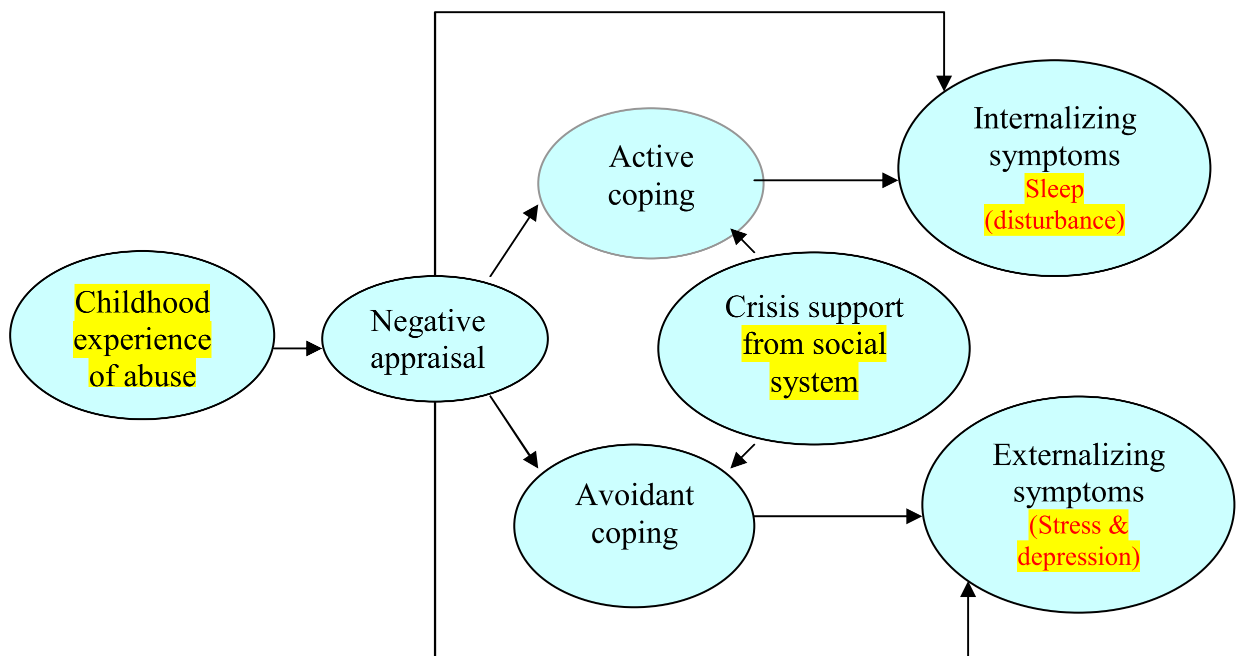

Figure 1: Spaccarelli hypothetical model for child abuse in adolescent

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1.5.1 Hypothesized model

Child abuse can take many forms (e.g. emotional, physical and sexual), and it can have numerous far-reaching effects on the victim, during the period of abuse and possibly throughout the victims life. The nature of these effects vary greatly, depending on the nature of the abuse, the characteristic of the victim, and the societal context in which the abuse takes place (also including the role of help and support for victims). Physical symptoms may include bodily injuries, which can result from beatings and other obvious, direct harm, and also sexual dysfunctions and other sexual injuries, possibly related to psychological issues. Psychological symptoms include a vast array of possible effects, which the victim may suffer from, psychological factors obviously include self-esteem issues and trauma resultant from abuse, but can also involve additional problems such as difficulty in concentrating (and academic underachievement). This study will look at the psychological and social consequences of child abuse on the victims, and how the victims (extending to their late-teens/early-twenties) perceive their experience, and how it has influenced their lives, and how this relates to the context of their society and their positions within it (i.e. socio-demographic factors). Based on the transactional theory of stress, it is hypothesized that psychological appraisal of a stressful event will predict coping styles employed to deal with the stressful event. The hypothesis suggests active coping and cognitive appraisal may mediate general psychological distress.

During the initial exposure to child abuse, victims typically respond with negative appraisals of self and others, and subsequently (if they are within a supportive social network), endeavor to repression, frustration and anger, which can later sublimate into serious mental implement coping strategies to help them manage and reduce stress. The ultimate success of coping strategies is measured by the victim’s ability to work

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through all negative feelings and thoughts concerning the abuse. The extent to which this is achieved varies. Lack of success in this is characterized by self-loathing, health issues for the victims of child abuse. It is proposed that unsuccessful coping will generally result in and internalizing symptoms such as anxiety, depression, post-traumatic stress disorder, and dissociation; and externalizing symptoms such as sleep disturbances, anger and sexual problems. Spaccarelli (1995) observed that the failure of coping in victims of child abuse could later develop into adult mental problems. This is believed to result from the negative initial responses to abuse; which if subsequently maintained and 'bottled up' (i.e. repressed) can lead to depression, anxiety and dissociation. However, even overtly 'dealing with' the child abuse by victims does not necessarily exorcize the negative psychological results; sometimes, additional problems may occur. For example, informing child care specialists such as teachers, charity workers and health care professionals may result in the child being ostracized within the community (presuming that the abuse does not come from such specialists themselves). However, it is certain that avoidance and repression of painful experiences of child abuse, in the absence of real coping methods and social support, can lead to trauma in the short term, and often to severe long term of mental and sexual illness in the long term (Spaccarelli, 1994).

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1.6. Variables of the study

Conceptual and Operational Definitions:

1.6.1 Independent variable

1. Child abuse

Conceptual definition**:** Child abuse "constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" (WHO, 1999).

Operational definition: Child abuse was measured by using Childhood Trauma Questionnaire-short form (CTQ-SF) developed by Bernestein & Fink (1998).

1.6.2 Dependent variables

2. Stress

Conceptual definition: Stress "is a broad class of experiences in which a demanding situation taxes a person's resources or coping capabilities, causing a negative effect" (Kneisl, Wilson, & Trigoboff. 2004. pp. 82).

Operational definition: Stress was measured by using Perceived Stress Scale (PSS). (Cohen, Kamarck, & Mermelstein. 1983)

3. Depression

Conceptual definition: Depression "Is a prominent and persistent disturbance in mood predominates in the clinical picture, and characterized by either (or both) of the following (depressed mood or markedly diminished interest or pleasure in all, or almost all, activity) or (elevated, expansive, or irritable mood)" (First & Tasman, 2004, pp 318).

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Operational definition: Depression was measured by using Trauma Symptom Checklist 40 (Briere & Runtz. 1998).

4. Sleep Disturbance

Conceptual definition: Sleep disturbance includes dyssomnia ; problem in regulation of amount and quality of sleep, and parasomnia; events that occur during sleep as sleep walking disorder (First & Tasman. 2004, pp 46).

Operational definition: Sleep disturbance was measured by using Trauma Symptom Checklist 40 (Briere & Runtz. 1998).

5. Social support

Conceptual definition: Social support is" a network of family, friends, neighbors, and community members that is available in times of need to give psychological, physical, and financial help (U S National Caner Institute, 2010).

Operational definition: Social support was measured by using Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet, & Farley. 1988).

* Demographic Characteristics

Conceptual definition: Demographic characteristics are defined as "student demographic (ages, gender, and college), parent demographic (age, marital status and level of education), monthly family household income, number of family member, student rank among family member, parents living arrangement (including the number of parents in the household and their relationship to the child), and place of residence".

Operational definition: Demographic characteristics were measured by using author-developed demographic profile based on the literature.

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1.7 Summary

This chapter introduced the statement of the problem, the purpose and research questions, conceptual framework, definitions of terms, and the significance of the study. The following chapter reviews the available literature on child abuse and psychosocial health disorders.

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CHAPTER TWO

2. Literature review

This chapter provides background information about the issue of child abuse in Jordan and worldwide. This chapter is organized into the following sections: definitions childhood abuse, prevalence childhood abuse, forms and severity of childhood abuse, psychosocial correlates of childhood experience of abuse, and abuse socio-demographic factors that affect and are affected by childhood abuse. Finally, substantive and methodological gaps in the literature are identified.

2.1. Definitions of childhood abuse

The lack of a universally-accepted definition of child abuse makes it difficult to calculate the number and severity of cases. An encompassing definition by the WHO defines child abuse as:

> "Bad treatment of a child under the age of 18 years by parents, caretaker, someone living in their home or someone who works with or around children. Forms of child abuse include physical, emotional, psychological, and sexual and neglect. Physical abuse refers to injury to a child that is not accidental. Emotional abuse occurs when a child is not nurtured and is not provided with love and security. Psychological abuse occurs when children are not provided with the necessary environment to develop mentally and/or emotionally. Sexual abuse is when the child is involved in any sexual activity with an adult or another child who is either older or more powerful. Neglect is depriving a child of their basic needs including food, clothing, warmth and shelter, emotional and physical security and protection, medical and dental care, cleanliness, education and supervision" (WHO, 1999, pp. 13-17).

Definition of childhood abuse vary and as mentioned above has no universally accepted form or type. For example, in the United States, Newton (2001) defined child abuse and neglect as "any recent act or failure to act on the part of parents or care taker which results in death, serious physical or emotional harm, sexual abuse or exhortation". The four main types of child abuse are physical, sexual, emotional, and neglect.

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In 2001 year, Jordan established National Council for Family Affairs (NCFA) under the chairmanship of Her Majesty Queen Rania Al-Abdullah. NCFA was developed as an umbrella organization to coordinate and facilitate the work of partners from national governmental and non-governmental institutions and the private sector involved in family affairs. The council seeks to strengthen the position of the Jordanian family, and to maximize their role in community enabling them to contribute to preserving the cultural heritage and value systems in line with the social and cultural changes in Jordan. Also, NCFA is an umbrella organization for issues related to childhood development protection services in Jordan and plays an important role the development of policies, standards, and creating a protective legislative environment for children. NCFA collaborates with UNICEF and Jordanian Ministry of Planning & International Cooperation to provide children with a secure environment making Jordan fit for children to grow and develop (National Council for Family Affairs, 2010).

National Council for Family Affairs in Jordan defines abuse and neglect as “any act, or the failure to prevent such an act, actual or threatened, against the self or any family member that results in injury, psychological harm, or deprivation. Such acts include neglect, exploitation, verbal abuse, and violation of one's basic rights including social and economic rights”. In this context, physical abuse includes such acts as beating and kicking, whereas psychological abuse includes ridicule and threats. Moreover, sexual abuse may refer to rape and sexual harassment. Neglect covers a broad range of acts that involve the denial of, or the failure to fulfill the basic needs of a family member (Shitiwi, Shakhatra, Gharibeh, & Oweis. 2005).

The review of literature regarding the definition of childhood abuse shed light on the importance of having a clear definition that is globally accepted. However, difficulties might arise related to cultural variations and socioeconomic norms and

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standards. Although the United Nations and local institutions around the world developed definitions, researchers are not in agreement on what definition should be used that is universally acceptable. In this study, the definitions of the WHO and the National Center for Family Affairs are adopted.

2.2. Prevalence of childhood abuse

The prevalence of child abuse varies across countries around the world. The problem is not limited to a specific population, culture or ethnic group. Although childhood experience of abuse has been addressed in the developed countries, the issue did not receive same attention in the literature in the developing countries. This might be related to underreporting of child abuse cases due to socio-cultural factors and sensitivities. Child abuse is expected to be underreported in Jordan as in most developing countries due to the conservative nature of the society. Cultural and family constraints could militate against reporting abuse (Jumaian, 2001). Cultural and familial constraints against reporting of abuse to authorities may contribute to exacerbating the psychological suffering of abused survivors in some conservative cultures (Back et al., 2003).

Estimates of the prevalence of child abuse in the countries vary widely between studies, in part due to the definition used of child abuse. Child abuse in the United States tends to be particularly prevalent (Sawyer, Di Loreto, Flood, DiLillo, & Hansen. 2002). In their landmark study, Sedlak et al. (2010) quantified the magnitude of the problem of childhood abuse in the United States. This study was reported in the Fourth National Incidence Study of child abuse and neglect (NIS-4). They reported that between 2005 and 2006, more than 1.25 million children experienced maltreatment. 44% of them, an estimated total of 553,300, were abused. 61%, an estimated total of 771,700, were neglected according to the Harm Standard (used since NIS-1) in order to

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classify harm as abuse or neglect (Sedlak et al., 2010); NIS-3 showed that 1,553,800 children were abused and neglected in 1993 (Sedlak, & Broadhust. 1996). The number of neglected children who fit the Harm Standard increased significantly from 474.800 during the NIS-2 data collection in 1986 to 879.00 at the time of the NIS-3 data period in 1993. Also, the number of abused children according to the Harm Standard rose by 46% from the year 1986 to 1993 (Sedlak et al., 1996). The NIS–4 estimate of the incidence rate per 1.000 children reflects a 19% decrease in the total number of maltreated children since the NIS–3 in 1993 (Sedlak et al., 2010). These statistics are almost certainly underestimates, because they only take into account reported cases.

Jordan, with a total population about six million, has 2,888,360 children under 19, representing 48.3% of the total population of Jordan (Department of Statistics in Jordan, 2009). The Jordanian Family Protection Department (FPD) reported that the total number of abused children in Jordan was 437 in 1998 and 569 in 1999. The data were categorized according to type of abuse, and showed that in 1998 the number of physical abuse cases was 145; sexual abuse, 176; and child neglect, 6. The numbers for the year 1999 were 223, 312, and 26 for physical abuse, sexual abuse, and child neglect (respectively). This increase suggests that the rate of abuse is increasing in Jordan, and/or that the FPD is becoming more successful in identifying abuse cases (Al-Hadidi, 2000, in Garaibeh & Hoeman, 2003).

Higher education system in Jordan has a major role in achieving comprehensive development at various levels and areas, and this system witnessed significant progress during the past few decades (Ministry of Higher Education & Scientific Research, 2011).

The Jordanian Higher Education System considers university education as a transitional period in the young adults' development and treats students as future

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decision makers. Furthermore, this system is acutely aware of the importance of university student health care by providing all university students in Jordan with health insurance coverage during their entire study at the universities. Moreover, the Jordanian Higher Education System assures all students the availability and access to health care by having a health center in each university to provide a variety of health care to students and university staff including screening, diagnosis, treatment and/or referral of cases to hospitals for admission to continue treatment and follow-up if needed. There are two university hospitals affiliated with two public universities. These hospitals provide health care for students, university staff, and the community (Ministry of Higher Education & Scientific Research, 2011).

Higher education system in Jordan, represented by it is governmental and non governmental universities has an important role in comprehensive development of screening and intervention programs on child abuse at various levels and areas through partnership with National Council for Family Affairs and other governmental and non governmental institutions to overcome child abuse issue (National Council for Family Affairs, 2010).

University students are at risk for a number of psychosocial and mental health disorders and adjustment problems including depression, substance use, and hostility. Moreover, those students who have these problems are more likely to life-long risk behaviors that may effect on their health status, academic achievement, and social functioning (Mansour, Halabi, & Dawani, 2009).

In general, data are not sufficiently available concerning Jordanian society compared to developed countries. The review of the Jordanian report and comparison of that with the international showed that there is a possible gap. Whether there is accurate

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or underreporting, there should be zero tolerance for child abuse therefore there is a need to examine this phenomenon further.

2.3. Forms and severity of childhood experience of abuse

Child abuse co-occurrence varies between studies and countries. Simon, Herlands, Marks, Mancini, Letamendi, Li, Pollack, Ameringen, & Stein (2009) recruited a total of 103 participants aged 18 and older in the USA, 72.9% (n = 72) men, from three center pharmacotherapy trials of generalized social anxiety disorder (GSAD). Those who met DSM-IV criteria for GSAD were interviewed by completing the Childhood Abuse Questionnaire (CTQ) and Liebowitz Social Anxiety Disorder Scale (LSADS) to assess the prevalence and impact of childhood abuse. 70% (n = 72) of participants reported that they had suffered at least one type of childhood abuse or neglect. The most frequent form of abuse reported by participants was emotional abuse 56% (n = 58), followed by emotional neglect 39% (n = 40), physical neglect 35% (n = 36), physical abuse 30% (n = 29), and sexual abuse 17% (n = 18). 16% (n = 17) of participants experienced two subtypes, and 16% (n = 17) of participants reported having experienced of three subtypes of abuse, and 8% (n = 8) of participants reported experiencing all forms of childhood abuse.

Childhood abuse occurrence in the USA was also assessed by using combined methodology of prospective and retrospective approach by Shaffer, Huston, & Egeland (2008). Data were collected from participants and their caregivers throughout childhood and adolescence through 19 years of age. A retrospective approach data collection was used prior to 17.5 years of age. Although they found that 20.6% of the sample cases of child abuse were identified through prospective approach, 7.1% were identified through retrospective approach, and 22.9% were identified through combination of method. In a study by Vranceanu, Hobfoll, & Johnson (2007), one hundred women with a mean age

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of 28.92 years were recruited from a gynecological treatment center in a mid-western city in the USA. Participants were asked of their childhood experience of abuse. Eighty-five (85) % reported that they have had at least one type of childhood experience of abuse when asked individually. Emotional abuse was reported as the most frequent type of abuse (66%), followed by witnessing family violence (39%), sexual abuse (36%) and neglect (35%). Fifty-six percent (56) %) of women reported that they had experienced a combination of physical abuse and neglect. Thirteen percent (13 %) of women reported that they had experienced all types of childhood abuse.

Childhood sexual and physical abuse and its later mental health impacts in 1,265 New Zealand children were assessed by Fergusson et al., (2008). Retrospective reports of childhood sexual abuse and physical experience of abuse were obtained from children at ages 18 and 21 years. They were asked about their experience of abuse before they were 16 years old. Results showed that 85.9% of the sample reported having no childhood experience of sexual abuse; 2.7% reported as having non-contact sexual abuse only; 5.1% reported as having contact sexual abuse not involving attempted or completed sexual penetration; and 6.3% had experienced attempted or completed sexual penetration including vaginal, oral and anal intercourse. Regarding childhood experience of physical abuse prior to 16 years of age, and based on parental physical punishment, the results indicated that 6.4% of the sample at ages 18 or 21 years reported that their parents had never used physical punishment; 11.2% stated that their parents seldom used physical punishment; 78.0% stated that at least one of their parents regularly used physical punishment; and 4.5% stated that at least one parent used frequent or severe punishment, or treated the participant in a harsh/abusive manner.

One study in Vietnam assessed the prevalence and impact of child maltreatment among a large sample (n = 2591) of students aged 12 to 18 years and 52.1% of

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participants were female (Nguyen, Dunne, & Vu Le., 2009). Two-thirds of participants (67.4%) had been victims at least one type of childhood abuse; 32.6%, 25.9%, 20.7%, 14.5% and 6.3% of students were also classified as having experienced nil, one, two, three, or all forms childhood abuse (respectively). In regard to serious types of child abuse, they were classified as having had experienced emotional abuse (39.5%), physical abuse (47.5%), sexual abuse (19.7%) and neglect (29.3%).

In Britain, a study by May-Chahal and Cawson (2005) found that 90% of participants lived with their parents. 16% of the sample indicated they had experienced sexual abuse (11%), physical abuse (7%), emotional abuse (6%), and neglect. The perpetrators of physical childhood abuse were 78%, 40%, and 15% by family member, peer, and teacher (respectively). For sexual abuse: with parents or caregivers, 1% of the sample had been sexually abused with contact, and less than 1% with non-contact; with non-related but known persons, 8% were sexually abused with contact, and 3% with non-contact; and with strangers, 2% had been sexually abused with contact and 2% had been sexually abused with non-contact (May-Chahal & Cawson, 2005).

While research in Jordan is limited, a number of studies examined the issue of childhood abuse. Gharaibeh and Hoeman (2003) used a descriptive qualitative approach to investigate the of child labor abuse. They found that boys reported all forms of abuse, including verbal, physical and sexual. Verbal abuse was usually from the employer and older boys. About 61% of those who participated in the study reported physical abuse, and considered it an accepted form of instruction. Twenty-seven (27) % reported sexual abuse by older boys. The abused boys were generally small, underachieving, and with low self-esteem. Another national study (Jumaian, 2001) found that 27% reported contact sexual abuse with adults when they were less than 14 years old.

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In Palestine, a study by Elbedour, Abu-Bader, Onwuegbuzie, Abu-Rabia, & El-Aassam (2006) examined the prevalence and scope of child abuse among young females in the Bedouin-Arab community of Palestine. Results showed that 53.3% of participants had experienced at least one type of sexual abuse, and the majority of perpetrators were strangers rather than family members (16% strangers, and 16% 'not friends'). Moreover, 89.6% of the participants had been physically abused at least once; 37.1%, 43.7%, 43.9%, 11.1%, 6.9% and 32.3% were abused by their fathers, mothers, siblings, uncles, aunts, and teachers or other individuals, respectively. More than 50% of the participants had experienced psychological abuse, with 60.9%, 54.2%, 48.9% and 42.4% having been psychologically abused by their siblings, mothers, fathers, and teachers, respectively.

2.4. Psychosocial correlates of childhood experience of abuse

The impact of child abuse is not momentary; it is expected that abused children will have short-term and long-term psychological effects that may influence societal structure and wellbeing. The literature links multiple childhood victimization with long-term negative outcomes.

It is a common finding that adverse experiences during childhood, such as child abuse, can lead to worse health outcomes for both genders in later life (Jewkes, Dunkle, Nduna, Jama, & Puren 2010). Jewkes and others (2010) studied 2,782 participants (1367 men and 1415 women) aged 15-26 years, from 70 rural villages in South Africa to assess the prevalence of childhood experiences of abuse and later health outcomes. The result of analysis showed that there was a consistent finding for incidence of HIV infections associated with women's childhood experience of emotional, sexual, and physical abuse. Also, there was a consistent finding that women with childhood experience of emotional neglect suffer depression, suicidal, and alcohol abuse.

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Regarding men, a consistent finding for childhood experience of emotional neglect is associated with depression and drug use. Also, men's childhood experience of sexual abuse is associated with depression and alcohol abuse.

A longitudinal study of over one thousand children in New Zealand was conducted by Fergusson et al., (2008) over a period of 25 years, from birth until the age of 25 years, to assess the mental health impact of childhood sexual and physical experiences of abuse in adulthood. Result showed that 22.5%, 23.5%, and 21.7% of children aged 16–18, 18–21, and 21–25 years (respectively) had major depression; 17.1%, 12.9%, and 18.2% of children aged 16–18, 18–21, and 21–25 years (respectively) had an anxiety disorder; 4.8%, 3.5%, and 3.0% of children aged16–18, 18–21, and 21–25 years (respectively) had conduct or anti-social personality disorder; 14.7%, 14.2%, and 12.4% of children aged 16–18, 18–21, and 21–25 years (respectively) had suicidal ideation; 3.6%, 3.7%, and 2.1% of children aged 16–18, 18–21, and 21–25 years (respectively) had attempted suicide; 8.6%, 11.0%, and 11.6% of children aged 16–18, 18–21, and 21–25 years (respectively) were substance dependent; and 61.1%, 61.9%, and 61.1% of the children aged 16–18, 18–21, and 21–25 years (respectively) reported having more than six kinds of DSM-IV mental health disorders. In addition, the results showed an association between childhood sexual abuse and later mental health outcomes including major depression, anxiety disorder, conduct/anti-social personality disorder, substance dependence, suicidal ideation, and suicidal behavior at ages 18, 21, and 25 years, although there was a high association between childhood sexual and physical abuse and high rates of all mental health outcomes at ages 18, 21, and 25 years. In addition, after controlling for the potential confounding factors of childhood sexual and physical abuse, the analysis showed that the association between childhood sexual abuse and later mental health outcomes remained the same,

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but the associations between childhood physical abuse and later mental health outcomes at ages 18, 21, and 25 years in all cases reduced in association with depression, suicide attempts, and overall rate of mental health outcomes at the same ages.

One of the causes of women's mental health problems is the impact of childhood experience of abuse (Fujiwara, Okuyama, Izumi, & Osada., 2010). Fujiwara and colleagues conducted a descriptive study of 421 Japanese mothers from 83 Mother-Child Home facilities, in which they reside to protect themselves from childhood abuse or domestic violence from their husbands or partners. They noted that 45.6% of the sample reported childhood experience of childhood abuse; 84.7% of the sample experienced domestic violence; and 41.5% of the sample reported both childhood experience of abuse and domestic violence. Although the results showed that childhood experience of abuse was associated with all symptoms of mental health disturbance, domestic violence in particular was associated with traumatic symptoms. Regarding subtypes of childhood experience of abuse, the series degree of association with women's mental health problems were emotional abuse, physical abuse, and neglect; also regarding subtypes of childhood abuse, childhood experience of physical abuse was the only one significantly associated with domestic violence. Domestic violence was significantly associated with dissociative and traumatic symptoms if women had no childhood experience of abuse; on the other hand, when participants reported childhood experience of abuse, domestic violence had no effect on dissociative and traumatic symptoms.

Poor health status can be present in women who are exposed to childhood sexual and physical abuse (Bonomi, Cannon, Anderson, Rivara, & Thompson., 2008). Bonomi and colleagues randomly recruited 3,568 women aged 18 to 64 in Washington State to assess the association between history of childhood physical and sexual abuse and later

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women health. They noted that 30.5% of the sample experienced childhood sexual and physical abuse before age 18 years; 6.4% of the sample reported physical child abuse only before age 18 years; 19.4% of the sample experienced sexual abuse only; and 6.9% of the sample reported both childhood sexual and physical abuse. In addition, the results showed that, regarding the poorest health, 7.4%, 10%, 9.5%, and 15.8% of the sample experienced fair/poor general health compared to no childhood experience of abuse, childhood experience of physical abuse only, childhood experience of sexual abuse only, and both physical and sexual abuse, respectively. Regarding depression, analysis indicated that the percentage ranged from highest percentage for depressive symptoms, 17.1%, 28.8%, 21.4%, and 38.25 for no childhood experience of abuse, childhood experience of physical abuse only, childhood experience of sexual abuse only, and both physical and sexual abuse, respectively; to lowest percentage for severely depressed, 8.5%, 18.3%, 10.8%, and 26.4% for no childhood experience of abuse, childhood experience of physical abuse only, childhood experience of sexual abuse only, and both physical and sexual abuse, respectively.

Child abuse has been associated with both social and psychological disturbance. In another longitudinal survey of 2,000 middle-aged men and women by Springer et al. (2007), it was found that 11.4% of the participants were physically abused (10.6% were males and 12.1% females). The study showed a positive relationship between histories of child abuse and increased occurrence of physiological problems, depression, anger and anxiety. Physical problems included allergies, arthritis/rheumatism, bronco asthma, bronchitis/emphysema, hypertension, and circulatory, cardiac, cardiopulmonary, and musculoskeletal system problems (Springer et al., 2007).

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2.5. Perceived social support

A quantitative study by (Vranceanu et al., 2007) explored the negative impact of childhood abuse on women's lives, and the association between multiple forms of childhood experience of abuse and women’s lower social support and higher stress in adulthood, and their subsequent susceptibility to symptoms of depression and posttraumatic stress disorder (PTSD). Data were collected from 100 women, recruited from a gynecological treatment center, as well as three female interviewers were trained in empathic questioning techniques and multi-cultural sensitivity. Significantly, they found a relationship between childhood abuse and PTSD, but no relation with depressive symptoms. They also found that social support was a significant mediator in the relationship between childhood abuse and PTSD. In addition, they indicated that stress played a mediating role in the relationship between childhood abuse and symptoms of depression in adulthood. In general, this study found that social support is considered a good mediator for adults with psychosocial disturbances such as depression and PTSD, especially for those with a childhood experience of abuse.

Powers, Ressler, & Bradley. (2009), cconducted a study of 378 participants (with 54% women) were recruited from the primary care and obstetrics gynecology clinic in Atlanta, Georgia. Data was collected by a trained interviewer using Beck Depression Inventory, Childhood Trauma Questionnaire, and Social Support Behaviors Scale to examine the relationship between childhood experience of abuse and adult depression and perceived family and friend support. They noted that there are relationships between all forms of childhood experience of abuse and adult depression and perceived family support. Also, they found the effect of childhood experience of emotional abuse and neglect more than of effect childhood experience of sexual and physical abuse on adult depression, especially in women. Further perceived friend

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support play a role as mediator for women who have experience stressful life events and those who are liable to progress of depression.

O'Dougherty Wright, Crawford, & Del Castillo (2009) conducted a study of a sample of 301 undergraduate students (143 men and 158 women), with a mean age of 20.37 years, to explore the long-term impact of child abuse in later life, and how severity of emotional abuse and neglect and dysfunction of family can be associated with later psychosocial problems, and how maladaptive internalized schemas can mediate the association between child emotional abuse and neglect and later psychosocial problems. They found that the perception of childhood emotional abuse and neglect contribute to later psychosocial problems after controlling socioeconomic variables and other forms of child abuse; maladaptive behavior like shame and other overwhelming feelings associated with childhood emotional abuse and neglect may lead to such emotional problems as dissociative tendencies in adulthood; and childhood emotional abuse and neglect and symptoms in adulthood were mediated by the internalized maladaptive shame and vulnerability to harm.

The role of shame in subsequent internalizing symptoms (depression and anxiety), and dissociative symptoms can be mediators of the relationship between childhood sexual abuse and interpersonal conflicts (parents and family conflict) (Kim, Talbot, & Cicchetti. 2009). The result of hierarchical regressions and logistic regression indicated that shame mediates the relationship between childhood sexual abuse and interpersonal conflict; women who had childhood experience of sexual abuse were more shameful in their life, and had interpersonal conflicts with parents and family.

Using reports of childhood sexual abuse and childhood relationships with mothers and peers and a modified version of the Composite International Diagnostic Interview produced life-time psychiatric diagnoses of four non-phobic anxiety disorders

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(Adams & Bukowski. 2007) assessed mother-child relationships and friendships as moderators in the relationship of childhood sexual abuse and later anxiety disorders. Results indicated that there was an effect for childhood sexual abuse on anxiety disorder; also those who reported high levels of friendship had a lower association between effects of childhood sexual abuse on anxiety disorder than those who reporting low level of friendship. However, those who reported high mother-child relationships and many friendships had the weakest association between effects of childhood sexual abuse on anxiety disorder compared to those reporting many friendships and a high mother-child relationship.

Wright, Fopam-loy, & Fisher (2005), hypothesized that partner support would moderate the severity of the effects of childhood sexual abuse, depression, health, and maternal competence, and the effects of depression on perceived health and maternal competence. Wright, Fopam-loy, & Fisher (2005) assessed women who had experienced childhood sexual abuse in the United States mainland and Hawaii and found that the majority of the sample reported that they had experienced moderate to severe levels of sexual abuse during preschool until late elementary school. The severity of the childhood experience of sexual abuse was weakly associated with outcome in the hierarchical regression analyses. In addition, 81.9% of mothers had evidence of positive adaptation in at least one domain, 18% had difficulty in every domain, and 53.8% had difficulty in two or more domains. Negative outcome across domains was associated with avoidant coping mechanism, and parental support played a role as a moderator between later depression and parenting competence.

2.6. Socio-demographic characteristics and childhood experience of abuse

Several studies have also looked at the association between childhood experience of abuse with socio-demographics and personal variables including gender,

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parental education level, parental marital status, and family household income, number of family children, living arrangement, and residence.

Gender at time of assessment in children or adults has been frequently examined in relation to childhood experience of abuse. Study findings were inconsistent. Most studies focused on adult female survivors rather than male survivors of childhood sexual abuse (CSA), especially if linked to the social reaction to disclosing childhood experience of sexual abuse (Ullman & Filipas. 2005). Ullman & Filipas conducted a large survey of 733 college students (71% female and 29% male), with an average age of 19.57 years, at an urban research university in the USA, to assess social reactions regarding disclosing the phenomena of CSA in both gender. Results showed that 22.8% of the total sample reported experience of CSA, while 28.2% of females and 13.3% of males experienced CSA. Most abuse (89.4%) was performed by a person known to the victims of CSA, most disclosed cases (87.9%) were purposeful, and most disclosed cases (74.5%) were of a vague and brief nature. Regarding gender and later effects of CSA, the results found that a significant effect of CSA on PTSD symptoms was in the timing of the disclosure CSA, although delayed disclosure in women was related to greater severity of PTSD symptom. No differences in timing of disclosure were found for men. In regression analysis, the results showed that there is no effect for gender on PTSD symptom.

Another study by Priebe and Svedin (2008), aimed to assess the association between disclosure rates and style with socio-demographic variables and characteristics abuse. They found that among 1,962 participants who reported experience of sexual abuse, 45.5% (n = 208) of the boys and 17.3% (n =261) of the girls did not answer disclosure questions. Both genders were likely to disclose their experience of more

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severe childhood sexual abuse to parents, siblings, and friends, while girls were more likely than boys to disclose their higher rates of severity of abuse to professionals.

Jewkes et al. (2010) assessed the prevalence of childhood experiences of adversity and later health outcomes in rural residents of South Africa. Participant's aged15 to 26 years were asked about their history of childhood abuse prior to the age of 18. The results indicated that both women and men reported experience of physical punishment (89.3% and 94.4%), physical hardship (65.8% and 46.8%), emotional abuse (54.7% and 56.4%), emotional neglect (41.6% and 39.6%), and sexual abuse (39.1% and 16.7%).

In the United States, a National Survey of Child and Adolescent Well-Being (NSCAW) study by Maikovich-Fong and Jaffee (2010) of 5,501 children (50% for each gender) to investigate gender in four forms of childhood sexual abuse, and how these forms were associated with emotional and behavioral disturbances. The results showed that both genders equally reported that they had more than one type of child abuse, and their abuser was a family member; adolescent girls reported more substantial forms of sexual abuse than boys, but no difference in other forms of sexual abuse. Results of MANCOVA showed that girls reported more severe sexual abuse with penetration than boys, and gender did not play a role as a moderator between abuse characteristics and emotional and behavioral problems of adolescents.

A retrospective study in Brazil used Childhood Trauma Questionnaire to investigate the frequency and severity of child abuse and neglect in an outpatient clinic for the treatment of alcoholism, drug dependence, and depression, and to compare them with a control group of medical outpatient clinic patients, and evaluate the effect of sex on those indicators. The result of analysis showed that alcohol-dependent women reported a higher frequency of physical abuse than men in the same group ($p = .001$).

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Regarding physical neglect, those women diagnosed with psychiatric problems in all groups found a higher frequency than men in the same group ($p < .05$). Regarding the control group, women experienced a higher frequency of physical abuse ($p < .03$), physical neglect ($p = .003$), and emotional neglect ($p < .001$) than men in the same group. Sexual abuse appeared to be associated with alcohol and drug dependence, while physical neglect in women associated with psychiatric diagnosis only, but emotional neglect was associated with alcohol dependence in both genders (Tucci, Kerr-Corrêa, & Souza-Formigoni. 2010).

Regarding residence, a cross-sectional survey conducted in rural areas for 1684 adolescents (756 indigenous and 928 non-indigenous) living in southern Taiwan by Yen, Yang, Yang, Su, Wang, & Lan (2008) assessed the prevalence and experience of adolescents' childhood experiences physical and sexual abuse. The analysis showed that 22.5% (n = 374) of the sample experienced of physical abuse (181 boys and 193 girls), and 2.5% (n = 42 adolescents reported childhood experiences of sexual abuse. Logistic regression analyses of the association between physical and sexual abuse, and socio-demographical variables, those participants who had poor family function and high conflict rate among family members experienced more childhood physical abuse. Furthermore, adolescents who had frequent family conflicts reported more childhood sexual abuse. There was a higher rate of childhood sexual abuse among adolescents who were indigenous and had frequent family conflicts. Regarding gender differences in the prevalence of childhood sexual abuse, the study found no significant differences in both indigenous and non-indigenous adolescents.

On other hand, several studies were conducted in urban areas. One of these was performed by Ye Luo, Parish, & Laumann (2008) with 1,519 women and 1,475 men aged 20 to 64 in the Chinese Health and Family Life Survey (CHFLS). This study

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examined the prevalence of childhood sexual abuse and the relationship with sexual and psychological distress. They found that 4.2% of urban participants had experienced childhood sexual abuse prior to the age of 14, (5.1% of men and 3.3% of women); 8.3% of those who had experienced such abuse were aged 20 to 29 years. 1.4% of women and 2.7% of men prior to the age of 12 had experienced at least one severe type of sexual contact. The study found that hyper-sexuality (e.g. high levels of masturbation, thoughts about sex, partner turnover, and varieties of sexual practices), sexual difficulties (sexually transmitted infections, sexual dysfunctions, and genitourinary symptoms), adult sexual victimization (unwanted sexual acts, sexual harassment, and unwanted sex), and sexual distress were common sexual disturbances among participants with a history of childhood abuse.

Family socioeconomic status (mainly determined by household income), family structure, and living arrangements play a role in the variance of childhood abuse in USA (Sedlak et al., 2010). Sedlak et al showed in the Fourth National Incidence Study of Child Abuse and Neglect (NIS–4) that the childhood abuse rate was higher among children in low socioeconomic status households in all forms of childhood abuse. Furthermore, children from such households reported at least one type of child abuse over five times more than other children, and were more than three times as likely to be abused, and seven times as likely to be neglected. They classified the living of children in NIS-4 into six categories. They found that lowest rate of experience of child abuse was among children living with their married biological parents, while the highest rate of childhood abuse was among those living with a single parent (eight times greater).

NIS-4 indicated that the rate of childhood abuse is related to the family size (Sedlak et al., 2010). Sedlak et al used the Harm Standard and Endangerment Standard to assess forms and severity of childhood abuse. Results showed children in larger

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families (with four or more children) had a higher rate of child abuse; family size of three children had an intermediate rate of child abuse incidence; and a family size of two children had a low rate of child abuse incidence.

2.7. Summary

In summary, the reviewed studies showed that childhood experience of abuse is a pervasive global problem. However, there is a need to develop a global definition of child abuse. The unavailability of consensus on the definition of child abuse has affected detecting and reporting accurate and comparative figures of prevalence, forms, severity of abuse and type of perpetrator. Inconsistent reports might be related to use of different methodologies and selection of different specific population groups. Whereas some studies used only one measure, others used various combinations comprised of two or more measures. In addition, there were limited qualitative studies investigating experience of child abuse, which broadens or diversifies the understanding of this phenomenon. The literature showed that childhood experience of abuse had negative impact on the victims, including physical, psychological, social and emotional health-related problems. Children who are exposed to childhood abuse suffered physical problems, psychological problems such as depression, anxiety, sleep disturbance, and sexual problems during adulthood compared to children who were not exposed to child abuse.

Childhood experience of abuse should be a priority for societies. Each society and each university or educational system within a society, where young adults learn to become active participants, productive members and leaders in their adulthood and later years, needs to further examine the phenomenon of childhood abuse. The negative impact of childhood experience of abuse influences or interferes with the individual student's growth, development, and learning and consequently contributes to serious

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physiological and psychosocial problems during adulthood. Examining prevalence, forms, and impact of childhood experience of abuse among the Jordanian population, therefore, will provide a better understanding of this problem and offer knowledge and information that can enhance better health care and social provision to victims.

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CHAPTER THREE

3. Methodology

This chapter presents the methodological premises on which this study was based including design, sample, setting, instruments, data collection procedure, protection of human rights, and data analysis. The research objectives were to: describe forms of childhood experience of abuse among university students in Jordan; explore the relationship between childhood experience of abuse and psychosocial disorders (depression, stress, and sleep disturbance, and perceived social support) among university students in Jordan; examine the relationship between severity of childhood experience of abuse and psychosocial disorders (depression, stress, and sleep disturbance) among university students in Jordan; and describe the difference in forms of childhood experience of abuse in relation to selected demographic and personal characteristics among university students in Jordan.

3.1. Study design

A quantitative approach utilizing a descriptive correlation cross-sectional design was used. Descriptive studies often lay the foundation for further, more rigorous studies (Polit & Beck, 2004). Given the gap in knowledge in Jordan related to the association between childhood experience of abuse and psychosocial health disorders among university students, this study was initiated.

3.2. Population

The target population of this study was the Jordanian universities students between ages of 17 to 25 years. This period of development (17-25 years old) is considered a transitional period between childhood and adulthood, and represent around 12% of Jordan population (Department of Statistics, 2009). The undergraduate level is

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selected for the purpose of maintaining the homogeneity of the sample and to maintain a narrow variation of the ages of participants.

The scientific rational for selecting the undergraduate students is because different studies revealed that such age group is more conducive to re-victimization (Widom et al., 2008; Barnes et al., 2009). In addition, this period is considered a period in which mental health problems start to show at the same time when the individual starts to be socially independent. The mental health problems such as depression, posttraumatic stress disorder, and sleep disturbances are more apparent in this age group (Buckle et al., 2005; Chiung-Tao Shen. 2009; Collishaw et al., 2007; Evans et al., 2005; Lang et al., 2006; Steel & Herlitz. 2005). Another reason for focusing on this age group is related to the higher recall ability of childhood experiences compared to those who are older (Melchert and Parker., 1996)

3.3. Sample and sampling

Convenience sampling technique was used in this study to recruit the sample of Jordanian university students. The overall aim of using convenience sampling technique was to obtain large sample size that can be representative for the population. Convenience sampling is a method of choosing subjects that are available or easy to find to get a gross estimate of the results without incurring the cost or time required to select a random sample (Panacek, 2007).

Inclusion criteria for the undergraduate students include:

1. Enrollment in the undergraduate programs at any faculty in the selected universities
2. Between 17-24 years of age.

No exclusion criteria were given to maximize participation and allow variation of the sample.

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3.4. Sample size

Sample size was calculated using a computer program (G-Power) (Faul and Erdfelder, 1992) with a small effect size of 0.10, at power of 0.80 and at 0.05, two-tailed level of significance, a total sample of at least 782 undergraduate students were required. Sample size was increased to 1500 to compensate for the suspected incomplete questionnaires, 1400 questionnaires were returned, giving a response rate of 93.3%.

3.5. Setting

Jordanian universities were categorized by the type of university sector: public or private. Each sector was categorized by the type and number of faculties and number of students. The majority of university students in Jordan are enrolled in public universities. Also, public universities receive students from all regions across Jordan. Two of ten public universities and two of seventeen private universities in Jordan were randomly selected from two boxes, first box consist ten papers represent public university, second box consist seventeen papers represent private universities, then the primary investigator shake it and somebody randomly select two paper from each box.

3.6. Measurements

A self administrated questionnaire consisting of Socio-demographics Data Sheet (SDS), Childhood Trauma Questionnaire-Short Form (CTQ-SF), Trauma Symptom Checklist-40 (TSC-40), Perceived Stress Scale (PSS), and Multidimensional Scale of Perceived Social Support (MSPSS) were used to collect data from 1400 university students.

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3.6.1 Socio-demographics Data Sheet (SDS)

The Socio-demographics Data Sheet (SDS) was developed by the researcher to elicit background information about the participants. The socio-demographic data include age, gender, university, faculty, parents educational level, parents age, parents marital status, family household income, living arrangement, number of male and female in family, and residence. See Appendix A.

3.6.2 Childhood Trauma Questionnaire-Short Form (CTQ-SF)

The Childhood Trauma Questionnaire-Short Form (CTQ-SF) developed by Bernstein & Fink, 1998 was administered as part of a large population survey to the participants of the study. To measure the childhood experience of abuse, the Childhood Trauma Questionnaire (CTQ) (28 item Short Form) was used. The CTQ consists of 25 clinical items measuring six factors and those are: physical abuse (five items), physical neglect (five items), emotional abuse (five items), emotional neglect (five items), and sexual abuse (five items). In addition, the CTQ has a three items measuring Minimization/Denial. Each item can be responded to and scored as *never true=1, rarely true=2, sometimes true=3, often true=4, very often true=5*. This means that for the total scale the expected range of scores is 28 – 134, while the subscales has a possible range of score of 5 to 25 exception the minimization/denial subscale which has a possible rang of 0 to 3. CTQ-SF scores were obtained by reversing responses (e.g., 1=5, 2=4, 3=3, 4=2, 5=1) to the items (2, 5, 7, 13, 19, 26, & 28), and then summing across all scale items. CTQ-SF Lower scores point to lower experience of childhood abuse, while higher scores suggest higher experience of childhood abuse. Bernstein et al. (2003) reported good internal consistency of the CTQ-SF for each of the abuse scales across 4 heterogeneous samples (physical abuse, 0.83-0.86; motional abuse, 0.84-0.89; and sexual abuse, 0.92-0.95). All questions in the CTQ_SF were equally weighted for each

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item: responses of students who have experienced abuse were given a value of one; responses of students who have not experienced abuse were given a zero. Unanswered questions were coded as missing and given a value of 99 (Hair, Tatham, Anderson, and Black (2006). Also, Bernstein et al. (2003) develop cut score to determine the severity of each forms of childhood experience of abuse as shown in table (1)

Table.1. Guidelines for Classification of CTQ Scale Scores

Scale	**None to Minimal**	**Low to Moderate**	**Moderate to Severe**	**Severe to Extreme**
Emotional Abuse	5-8	9-12	13-15	≥ 16
Physical Abuse	5-7	8-9	10-12	≥ 13
Sexual Abuse	5	6-7	8-12	≥ 13
Emotional Neglect	5-9	10-14	15-17	≥ 18
Physical Neglect	5-7	8-9	10-12	≥ 13

3.6.3 Trauma Symptom Checklist-40 (TSC-40)

Trauma Symptom Checklist-40 (TSC-40; Briere & Runtz, 1989; Elliott & Briere., 1998). The TSC-40 consists of 40 items, each rated on a four-point rating scale (0 = *never true*; 1 = *rarely true*; 2 = *sometime true*; 3 = *often true*) that assessed adult symptoms associated with traumatic childhood or adult experiences of child abuse during the past two months. The TSC consists of 40 items measuring six factors and those are: Dissociation (five items), Anxiety (eight items), Depression (nine items), Sexual Abuse Trauma Index (seven items), and Sleep Disturbance (six items) and Sexual Problems (eight items). Two subscales (depression and sleep disturbance) were used from TSC battery. The depression and sleep disturbances subscale have a possible range of 1 to 13. Each symptom item is rated according to its frequency of occurrence over the prior two months. The higher the degree of traumatic symptoms is considered a risk factor for a clinical psychiatric disorder. The TSC demonstrates strong internal

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reliability for subscale which ranged from .66 to .77, with alphas for the full scale averaging between .89 and .91; Briere & Runtz, 1989; Elliott& Briere., 1992).

3.6.4 Perceived Stress Scale (PSS)

Perceived Stress Scale (PSS) was used to measure perceived stress (Cohen et al. 1983). The PSS is a ten-item questionnaire that measures the degree to which life situations are appraised as stressful. Each item on the PSS is rated on a four-point rating scale ranging from never (0) to very often (4). PSS scores are obtained by reversing responses coding (e.g., 0=4, 1=3, 2=2, 3=1 & 4=0) to the four positively stated items (items 4, 5, 7, & 8) and then summing across all scale items. One-half of the items are written in positive form (e.g., in the last month, how often have you felt that you were on top of things?). The other half of the questionnaire was written in a negative form (e.g., in the last month, how often have you found that you could not cope with all the things that you had to do?). The expected score rang from 0 – 40. Higher degrees and longer duration of self-perceived stress indicated by a higher score and is considered a risk factor for a clinical psychiatric disorder. In other ward the higher score is the higher perception of stress. In this study, the internal consistency (Cronbach's alpha) for the total scale was 0.68.

3.6.5 Multidimensional Scale of Perceived Social Support (MSPSS)

Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet, Dahlem, Zimet, & Farley., 1988). This 12-item scale was used to assess perceptions of adequacy of social support from the following three sources including: family, friends and significant others such as health care providers. Each item was measured using a 7-point Likert scale ranging from 1 (very strongly disagree) to 7 (very strongly agree). The scale has three sub scales, family (items 3,4,8, &11), friends (items, 7,9,&12), and significant others (items, 1,2,5,&10). The total score ranges from 7 to 84 and the score

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for each subscale ranges from 4 to 28. MSPSS lower scores indicate low adequacy of perceived social support, while higher scores suggested more adequate perceived social support. The reliability, validity and factor structure of the MSPSS had been demonstrated across different populations reported Cronbach’s alpha coefficient for MSPSS ranged from .92 to .98. (Zimet, Dahlem, Zimet, & Farley., 1988).

The above instruments were derived from the literature, and the authors’ permission has been sought and granted to use of them.

3.6.6 Validity and reliability of instruments in the current study

An official translation was appointed from the author's to translate the survey instruments and other related materials into Arabic. The self- administered questionnaire was translated to the Arabic language and back translated by an expert panel consisting of six nursing experts in mental and community health to assure accuracy and face and content validity of the instruments. In addition, the appropriateness of questions to the Jordanian culture was evaluated because of the culturally sensitive nature of all forms of child abuse questions elicited by the research instruments.

A pilot study was conducted with 50 students from the same settings after obtaining their informed consent was given to participate in the study. The purposes of the pilot testing was to identify reading and understanding difficulties, time required for completing the questionnaires and to determine reliability of measures in Arabic language. Cronbach's -alpha reliability coefficient was used to ascertain the appropriateness of the design. Results of the pilot study showed that students found the questions easy to understand and required only 25-30 minutes to complete. Results of the Cronbach's -alpha reliability coefficient of the CQT, TSC, PSS, and MSPSS for the

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pilot study were 0.92, 0.86, .67, and 0.87, respectively, and for the main study were 0.82, .83, 66, 82, respectively (Table 2).

Table 2: Cronbach's Alpha Reliability for CQT, TSC, PSS, and MSPSS in Arabic Version.

Scale	No. of Items	Cronbach's alpha reliability For the pilot study, n = 50	Cronbach's alpha reliability For the main study, n = 1400
CQT	28	.92	.82
TSC	13	.86	.83
PSS	10	.67	.66
MSPSS	12	.87	.82

3.7. Ethical consideration

This study was conducted with thoughtful consideration of the ethical implications at each phase of the research process. Approval from IRB at University of Jordan was obtained in order to conduct the study. The primary investigator asked for permission from the IRBs at two public universities and two private universities. As soon as the study started and once a clear plan for conducting the study was established, the chosen Jordanian universities were approached for their consent. The relevant faculties in chosen Jordanian Universities were contacted and an application for ethical approval was completed and attached to the study proposal. Although, the application process through Jordanian Universities was lengthy, consent was forthcoming, and permission to proceed with the study was secured.

In relation to the questionnaires used during the first phase, an explanatory cover letter was attached to the questionnaires. This cover letter informed the reader of the importance of their participation and completing the questionnaires. The cover letter also explained the broad purpose of the study, identified the researcher, and encouraged the participants to ask questions and seek clarification.

3.7.1 Voluntarily participation

The right to voluntary participation is a well-established principle of social research (Babbie, 2005). Therefore, at all times during the entire study period

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participants were not induced or coerced to believe that as students, they are required to take part in the study or that their status as university students will be affected by their participation in this study. For this reason, at every stage of the research process, the potential participants were advised of the voluntary nature of their participation and that they could withdraw from the study at any time, and failure to participate in the study or withdrawal at any stage would not result in any penalty or loss of benefits to which the participants are entitled or affect their grade in the course. Potential participants also were advised that they could decline to answer any question.

3.7.2 Anonymity and confidentiality

The International Council of Nursing (ICN, 1996) suggested that beneficence, fidelity, justice, veracity and confidentiality should be considered as acceptable guidelines for nursing research. Issues of anonymity and confidentiality were addressed by explicitly informing potential participants before, during, and after study completion. In addition, every effort made to ensure the study reports do not break the informant's confidentiality and anonymity in any way. The completion and return of the questionnaires remained completely within the domain of the study participant's control. To further ensure confidentiality, participants were assured that the data would only be available to the researcher, and would not be used by somebody else without the consent of the participants.

As the research is based on student's experiences of childhood abuse, and not an intervention study therefore the results may encourage reporting of childhood experience of abuse and enhance development of interventions for adolescents and young adults who have experienced abuse during childhood.

Every principal investigator of every research study that uses human subjects as participant has the duty and responsibility to protect every participant's rights to respect,

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privacy and anonymity (Kalantri, 2003). Such protection for participant's rights comes from the ethical principles of voluntary participation and obtaining informed consent (Kalantri, 2003). In this study these principles were followed and each participant was assured they will not be exposed to any form of harm. Furthermore, each participant's rights to privacy, anonymity, confidentiality, and self-determination were protected. To assure the participant's anonymity, each participant was instructed not to write down their names on any where of the package.

3.8. Data collection procedure

This study was conducted using a multi-strategic sampling technique (Polit & Beck, 2004). At the beginning, stratifying sampling technique was used to randomly select two public and two private universities in Jordan using information from the Ministry of Higher Education. Then two courses out of all elective courses and two classes per course in the selected universities were randomly selected utilizing information from the registrar's office at each university related to number of proposed section for each elective course. Then a selection of two to three sections of the selected courses were randomly selected utilizing information from the registration's office according to number of students registered at each section.

The targeted universities were contacted to assign a facilitator who can assist and facilitate approaching students and collecting data. The facilitators contacted faculties and instructors to schedule data collection during their class time. The research team of primary investigator and four trained research assistants who trained and participated in data collection of previous studies visited the instructors prior to entering their classes to explain the study to them, answer their questions, and ask for their cooperation. The research team entered the selected classes and provided information about the purpose of the study, and what participants are expected to do, the

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significance of the study, and the rationale for asking for their contact information, anonymity, and confidentiality for their participation in the study. All students expressed their interest in participation and provided with the package of self-administered questionnaire and an author-developed demographic to fill out and return to a separate box that was put at the podium in the front of the class room. Trained research assistants were available to assist in data collection and recruitment of the sample.

Data collection was performed in scheduled manner from students in group sessions during class hours. At each section (class) students were recruited using convenience sampling technique. The time needed to complete filling the questionnaires and checklists was 25 to 30 minutes. Data collection took place over a period of four months from July to November 2010.

3.9. Statistical analysis

Data were analyzed using the Statistical Package for Social Sciences (SPSS) version 15. First research question about forms of childhood experience of abuse among universities students were measured by using the central tendency measures (mean and median) and the dispersion measures (standard deviation and range). The obtained descriptive statistics were compared to other normative samples in the literature. Also descriptive statistics were used to describe the demographic characteristics of the participants. The descriptive statistics were also used to test the underlying assumption of normality, linearity, homogeneity, and independence of observations.

Inferential statistics in terms of Pearson correlation and standardized regression were used to examine second research question regarding the relationship between child experience of abuse and psychosocial health disorders, with 95% confidence intervals and to examine the most important predictors of child abuse experience and

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psychosocial health disorders. Pearson correlation was used to explore the relationship between severity of childhood experience of abuse and psychosocial health disorders. Demographic variables were reported, and tests for differences were conducted using ANOVA, t- test, and Pearson correlation were used to , t-tests and Pearson correlations were used to examine the differences and the relationships of students socio-demographic variables on childhood experience of abuse.

3.10. Questionnaire data preparation and cleaning

The primary investigator entered the survey data into the statistical program, SPSS (15). Data were categorized in 5 sections: socio-demographic data, childhood experience of abuse data, depression, stress, sleep disturbances, and perceived social support data. Some returned questionnaires were excluded from data entry because they were incomplete; missing values were coded as 99. To minimize errors, no calculations or reverse score entries were performed during data entry.

Data cleaning involved number of types of checks at different stages of data analysis (Hair et al., 2006). First, an assessment of outliers (values outside the normal range of values) was performed. Outliers were checked by examining the frequency distributions for each question, so that incorrectly coded data could be identified. Next, an assessment of internal data consistency was performed to check that the data entry in one part of the record was compatible with data in another part.

3.11. Summary

This chapter provided a description of the design and methods used in this study. A convenience sample of 1400 Jordanian universities students from two public and two private universities was chosen for data collection. A self administered questionnaire was used, which consists of five sections: socio-demographic data sheet, CQT-SF, TCS-40, PSS, and MSPSS. Results of the study are presented in the next chapter.

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CHAPTER FOUR

4. Results

This study aimed to determine the forms of childhood experience of abuse among university students in Jordan, and to describe the relationship between childhood experience of abuse and psychosocial disorders (depression, stress, sleep disturbance, and perceived social support). In addition, the study examined the relationship between severity of childhood experience of abuse and the psychosocial disorders to determine the differences between forms of childhood experience of abuse in relation to selected socio-demographic variables. This chapter presents results of the data analysis regarding childhood experience of abuse and psychosocial health disorders related to the research questions.

4. 1. Descriptive characteristics

A total of 1400 students participated in this study. Table 3 A and B presents findings of the demographical characteristics of the students. The age of participants ranged from 18 to 25 years with mean age of 21.0 years (SD = 1.4). Sixty percent (60.1%) (n = 842) were females and 39.9% (n = 558) were males. The majority of the participants were enrolled in public universities (67.1%, n = 940), and 32.9% (n = 460) were enrolled in private universities. The students representing the humanities faculties were 47.8% (n = 809), 24.6% (n = 364) were enrolled in the scientific faculties, and 16.2% (n = 227) came from health sciences faculties.

Regarding paternal level of education, 3.9% (n = 55) of participants reported that their fathers were illiterate, 40.4% (n = 566) reported their father had high school level education or less, 11.8% (n = 165) had diplomas, 30.1% (n = 421) had baccalaureate degree, and 13.8 (n = 193) had masters and/or PhD degrees. Also, the participants reported that their mother's levels of education were: illiterate 9.1% (n =

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128), high school level or less 50.4% (n = 706), diploma level 17.4% (n = 244), baccalaureate degree 19.4% (n = 271), and graduate level 3.6% (n = 51). The mean family monthly income was 883.65 (SD = 99.12) Jordanian dinars (JOD), ranging from 100 to 9,000 JOD. The majority of participants lived in rural areas during their childhood 65.6% (n = 918), while 30.6% (n = 429) of the participants lived in urban areas, 2.4 % (n = 34) lived in camps, and only 1.4% (n = 19) lived in the Bedouin regions.

Table 3.A: Descriptive characteristics of the participants (N = 1400)

	Mean	SD	Min	Max
Student age (years)	21.02	1.35	18	25
Father age (years)	54.32	7.40	39	84
Mother age (years)	47.96	6.23	35	72
Monthly Income of family (JOD)	883.65	99.12	100	9000

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Table 3.B. Frequency distribution of demographic variables of participants (N = 1400)

Variable	Status	n	%
Gender			
	Male	558	39.9
	Female	842	60.1
Marital status			
	Single	1289	92.1
	Married	97	6.9
	Divorced	10	.7
	Widowed	4	.3
University			
	Public	940	67.1
	Private	460	32.9
Faculty			
	Humanities	809	57.8
	Scientific	364	26.0
	Health	227	16.2
Father's educational level			
	Illiterate level	55	3.9
	High school level or less	566	40.4
	diploma degree	165	11.8
	baccalaureate degree	421	30.1
	Graduate level	193	13.8
Mother's educational level			
	Illiterate level	128	9.1
	High school level or less	706	50.4
	Diploma degree	244	17.4
	baccalaureate degree	271	19.4
	Graduate level	51	3.6
Marital status of parents			
	Married and living together	1209	86.4
	Divorced	48	3.4
	Married but not living together	25	1.8
	Widow	118	8.4
Residence			
	Rural area	918	65.6
	Urban area	429	30.6
	Bedouin area	19	1.4
	Palestinian Refugee Camps	34	2.4

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4.1.2 Childhood experience of abuse among Jordanian university students

The research question regarding forms of childhood experience of abuse was measured using CTQ-SF. Subscales of CTQ-SF include physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, and minimization/denial.

The results showed in quartile test that students had low to moderate reports of childhood experience of abuse (see appendix J). The highest response reports of disagreement (Never True) were observed in item 24 (Someone molested me, 93.5%), item 27 (I believe that I was sexually abused, 93.2%), item 6 (I had to wear dirty clothes, 92.2%), and item 4 (My parents were too drunk or high to take care of the family, 89.9%). The lowest response reports (Never True) were in items (My family was a source of strength and support, 2.9%), item 13 (People in my family looked out for each other, 3.0%), and item 7 (I felt loved, 3.6%). Also, the analysis showed that response reports in (Rarely True) for all items were equal and lower than 18.1% of responses, as in item 3 (People in my family called me things like “stupid”, “lazy”, or “ugly”), item 14 (People in my family said hurtful or insulting things to me, 18.1%), and item 12 (I was punished with a belt, a board, a cord, or some other hard object, 15.6%). While the highest responses reports (Sometimes True) were in items 10 (There was nothing I wanted to change about my family, 26.6%), 16 (I had the perfect childhood, 18.0%), and 5 and 25 (I had the perfect childhood; and I believe that I was emotionally abused, 15.4%). All (Often True) responses were less than 34%, as in item 16 (I believe that I was physically abused, 33.9%), item 7 (I felt loved, 33.0%), and item 19 (People in my family felt close to each other, 31.9%). Students had the highest agreement responses (Very Often True) in item 2 (I knew there was someone to take care of me and protect me, 70.1%), item 28 (My family was a source of strength and support, 63.1%), and item 26 (There was someone to take me to the doctor if I needed

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it, 59.1%). The lowest responses of (Very Often True) were in items 21 (Someone threatened to hurt me or tell lies about me unless I did something sexual with them, 0.9%), 1 (I didn't have enough to eat, 1.4%), and 4, 27, and 6 (My parents were too drunk or high to take care of the family; I had to wear dirty clothes; and I believe that I was sexually abused, 1.5%).

Regarding the mean scores of all items using the total mean scale, the analysis (see table 4) showed that the subjects' mean scores for all items ranged from 1.11 to 4.39. The highest mean was observed in item 28 (My family was a source of strength and support, 4.39), item 2 (I knew there was someone to take care of me and protect me, 4.34), and item 26 (There was someone to take me to the doctor if I needed it, 4.19), while the lowest mean was observed in items 21 (Someone threatened to hurt me or tell lies about me unless I did something sexual with them, 1.11), item 6 (I had to wear dirty clothes, 1.14), and items 24 and 27 (Someone molested me; I believe that I was sexually abused, 1.15).

4.1.3 Forms of childhood experience of abuse among Jordanian university students

Students who reported childhood experience of abuse were compared with those who reported no childhood experience of abuse. The responses to the Childhood Trauma Questionnaire (CTQ) were collapsed into yes (rarely to very often) versus no (never true). The analysis (see table 4) showed that the mean score of the total scale was 9.83 (SD = 4.49), which is similar to the expected scores of the scale that rang from 0 to 28. The analysis also showed that about 25% of the students had a score of 9 or lower, and about 25% of them had a score 12 or higher, which means that about 50% of the students had a score of between 9 and 12. The results indicate that students in general reported low to moderate childhood experience of abuse. Regarding the CTQ-SF subscales (physical abuse, sexual abuse, emotional abuse, physical neglect, emotional

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neglect, and minimization/denial), the mean scores ranged from 0.45 (SD = 1.09) for the emotional abuse scale, to 2.71 (SD = .58) for the minimization/denial scale. Results indicate that the most common form abuse reported by students was childhood experience of emotional abuse, while the lowest form of abuse reported by students was minimization/denial of abuse. Moreover, the analysis showed that the majority of students 79.8% (n = 1117) reported that they had childhood experience of emotional abuse, 53.7% (n = 754) reported that those experienced sexual abuse, 27.9% (n = 391) reported childhood experience of physical abuse, 13.5 (n = 189) reported childhood experience of physical neglect, 3.5 (n = 49) reported childhood experience of emotional neglect, and 1.3% (n = 18) reported minimization/denial of abuse.

Regarding the mean score of items CTQ-SF subscales, the lowest scores were observed in item 8 (I thought that my parents wished I had never been born; M = .19, SD = .39), item 18 (I felt that someone in my family hated me; M = .32, SD = .46), item 3 (People in my family said hurtful or insulting things to me; M = .34, SD = .47), item 14 (People in my family called me things like “stupid”, “lazy”, or “ugly”; M = .36, SD = .48), and item 25 (I believe that I was emotionally abused; M = .49, SD = .50). The highest mean values in the CTQ-SF were observed in the Minimization/Denial subscale (M = 2.71, SD = .58). The highest reported item was item 22 (I had the best family in the world; M = .96, SD = .20), while the lowest was item 10 (There was nothing I wanted to change about my family; M = .79, SD = .41).

Interestingly, about 36.7% (n = 514) of students reported having been punished with a belt, a board, a cord, or some other hard object, and 19.1% (n = 267) of them believe they were physically abused. Furthermore, 12.8% (n = 179) and 12.7% (n = 178) reported that someone tried to touch them in a sexual way or tried to have them touch their bodies, and someone tried to make them do sexual acts or watch sexual acts

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(respectively). In addition, 48.7 % (n = 682) of students reported that they were emotionally abused, 35.9% (n = 502) had people in their family who called them names as “stupid”, “lazy” or “ugly”, and 34.1% (n = 477) reported people in their family said hurtful or insulting words to them. About 91.9% (n = 1287) of students reported that there was someone to take them to the doctor if they needed it, and 90.7% (n =1270) of them knew that there was someone to take care and protect them. 97.1% (n = 1360) of the students reported that their families were a source of strength and support, 97.0% (n = 1358) reported that their family members looked out for each other, and 96.4% (n = 1350) felt loved.

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Table 4: Childhood experience of abuse domains among university students in Jordan (N=1400)

	Items	Ever had childhood experience of abuse		Min	Max	Mean	SD
		n	%				
	Physical abuse	**391**	**27.9**	**0**	**5**	**1.69**	**1.51**
1	I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.	163	18.9	0	1	.12	.32
2	People in my family hit me so hard that it left me with bruises or marks	227	16.2	0	1	.16	.37
3	I was punished with a belt, a board, a cord, or some other hard object	514	36.7	0	1	.37	.48
4	I believe that I was physically abused.	267	19.1	0	1	.19	.39
5	I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or doctor.	155	11.1	0	1	.11	.31
	Sexual abuse	**754**	**53.9**	**0**	**5**	**.95**	**1.34**
6	Someone tried to touch me in a sexual way, or tried to make me touch them	179	12.8	0	1	.13	.33
7	Someone threatened to hurt me or tell lies about me unless I did something sexual with them.	82	5.9	0	1	.06	.23
8	Someone tried to make me do sexual things or watch sexual things.	178	12.7	0	1	.13	.33
9	Someone molested me.	91	6.5	0	1	.07	.25
10	I believe that I was sexually abused	95	6.8	0	1	.07	.25
	Emotional abuse	**1117**	**79.8**	**0**	**5**	**.45**	**1.09**
11	People in my family called me things like “stupid”, “lazy”, or “ugly”.	502	35.9	0	1	.36	.48
12	I thought that my parents wished I had never been born	265	18.9	0	1	.19	.39

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13	People in my family said hurtful or insulting things to me.	477	34.1	0	1	.34	.47
14	I felt that someone in my family hated me.	442	31.6	0	1	.32	.46
15	I believe that I was emotionally abused.	682	48.7	0	1	.49	.50
	Physical neglect	**189**	**13.5**	**0**	**5**	**2.52**	**1.67**
16	I didn't have enough to eat.	163	11.6	0	1	.12	.32
17	I knew there was someone to take care of me and protect me.	1270	90.7	0	1	.91	.29
18	My parents were too drunk or high to take care of the family.	141	10.1	0	1	.10	.30
19	I had to wear dirty clothes	109	7.8	0	1	.08	.27
20	There was someone to take me to the doctor if I needed it	1287	91.9	0	1	.92	.27
	Emotional neglect	**49**	**3.5**	**0**	**5**	**1.51**	**.86**
21	There was someone in my family who helped me feel important or special	1312	93.7	0	1	.94	.24
22	I felt loved	1350	96.4	0	1	.96	.19
23	People in my family looked out for each other	1358	97.0	0	1	.97	.17
24	People in my family felt close to each other.	1315	93.9	0	1	.94	.24
25	My family was a source of strength and support.	1360	97.1	0	1	.97	.17
	Minimization/Denial	**18**	**1.3**	**0**	**3**	**2.71**	**.58**
26	There was nothing I wanted to change about my family	1110	79.3	0	1	.79	.41
27	I had the perfect childhood	1333	95.2	0	1	.95	.21
28	I had the best family in the world	1344	96.0	0	1	.96	.20
Total scale of CTQ-SF				**0**	**28**	**9.83**	**4.49**

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4. 2 .1 Relationship between childhood experience of abuse and psychosocial disorders (stress, depression, sleep disturbance, and perceived social support)

The second question related to the relationship between childhood experience of abuse domains and depression, sleep disturbances, stress, and perceived social support were answered using Pearson product-moment correlation coefficient (r). As shown in table 5.A, the analysis showed that physical abuse had a positively correlated with depression (r = .45, p <0.001), sleep disturbances (r = 0.36, p < 0.001), and stress (r = .18, p <0.001), although, negatively correlated with perceived social support (r = -.27, p <0.001). Regarding sexual abuse, there was a positive correlation with depression (r = .31, p <0.001), sleep disturbances (r = .21, p < 0.001), and stress (r = .14, p <0.001), although, there was a negatively correlated with perceived social support (r = -.20, p <0.001). Regarding emotional abuse, there was a positive correlation with depression (r = .29, p <0.001), sleep disturbances (r = .18, p < 0.001), and stress (r = .06, p <0.001), and negatively correlated with perceived social support (r = -.17, p <0.001). This suggests that students who reported higher scores of childhood experience of physical, sexual, and emotional abuse are more likely to report higher level of depression, stress, and sleep disturbances, while those students with higher scores of childhood experience of physical, sexual, and emotional abuse are less likely to report higher perception of perceived social support. Regarding physical neglect, the analysis showed that physical neglect has no significant correlation with stress. While there was a positive correlation with depression (r = .29, p <0.001) and sleep disturbances (r = .19, p < 0.001), and negatively correlated with perceived social support (r = -.31, p <0.001). Regarding neglect, the analysis showed that has no correlation with stress. However, there was a positive correlation with depression (r = .09, p <0.001) and sleep disturbances (r = .07, p < 0.007), and a negatively correlated with perceived social support (r = -.08, p <0.003).

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This suggests that students who reported higher scores of childhood experience of physical and emotional neglect are more likely to report higher level of depression, and sleep disturbances, while those students with higher scores of childhood experience of physical and emotional neglect are less likely to report higher perception of perceived social support. Regarding minimization/denial, there was a positive correlation with perceived social support ($r = -.30$, $p < 0.001$), and negatively correlated with depression ($r = -.32$, $p <0.001$), sleep disturbances ($r = -.24$, $p < 0.001$), and stress ($r = -.09$, $p <0.001$). This suggests that students who reported higher scores minimization/denial of abuse are less likely to report higher level of depression, stress, and sleep disturbances, while those students with higher scores of minimization/denial are more likely to report higher perception of perceived social support.

In general, Pearson product-moment correlation coefficient (r) infers that childhood experience of abuse was positively and correlated with depression ($r = .40$, $p <0.001$), sleep disturbances ($r = .28$, $p < 0.001$), and stress ($r = .10$, $p <0.001$), although negatively correlated with perceived social support ($r = -.26$, $p <0.001$). This suggests that students who reported higher scores of childhood experience of abuse are more likely to report who reported higher level of depression, stress, and sleep disturbances, and students with higher scores of childhood experience of abuse are less likely to report higher perception of perceived social support.

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Table 5.A: The relationships between psychosocial health impact, childhood abuse, and perceived social support among university students n Jordan (N=1400)

Variable	Depression	Sleep disturbances	Stress	Perceived social support
Physical abuse	.45**	.36**	.184**	-.27**
Sexual abuse	.31**	.21**	.14**	-.20**
Emotional abuse	.29**	.18**	.06*	-.17**
Physical neglect	.29**	.19**	-.01	-.31**
Emotional neglect	.09**	.07**	-.01	-.08**
Minimization/denial	-.32**	-.24**	-.09**	.30**
Child abuse experience	.40**	.28**	.10**	-.26**

* Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).

The second research question aimed to determine the relationship between childhood experience of abuse and psychosocial health disorders. Standardized regression was used concerning the prediction of the psychosocial impacts of childhood experience of abuse and to assure that the correlation magnitudes not effect on correlation especially the magnitudes Pearson correlation were low. The analysis (see table 5.B) showed that childhood experience of minimizations/denial, emotional abuse, and physical abuse were significant predictors for depression among university students (β = - .30, .30, & .59, p > .05, respectively). The analysis shows that about 24% of changes in depression score are related to the changes in scores of childhood experience of physical abuse, emotional abuse, and minimizations/denial (R^2 = .24). This suggests that students who reported higher scores of childhood experience of emotional and physical abuse are more likely to report higher levels of depression. While those students who reported higher scores of minimization/denial of abuse are less likely to report higher levels of depression. Childhood experience of minimizations/denial and physical abuse were significant predictors for sleep disturbances among university students (β = - .20 and .43, p > .05, respectively). The analysis shows that about 14% of changes in sleep disturbances score is related to the changes in the scores of childhood

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experience of physical abuse, emotional abuse, and immunizations/denial (R^2 = .14). This suggests that students who reported higher scores of childhood experience of physical abuse are more likely to report higher level of sleep disturbances, and students who reported higher scores of minimization/denial of abuse are less likely to report higher level of sleep disturbances. Childhood experience of physical abuse, physical neglect, and minimization/denial were significant predictors for stress among university students (β = - .23 to .35, $p > .05$, respectively). The analysis shows that about 6% of changes in sleep stress score are related to the changes in scores of childhood experience of physical abuse, physical neglect, and minimization/denial (R^2 = .06). This suggests that students who reported higher scores of childhood experience of physical abuse are more likely to report higher levels of stress, and students who reported higher scores of physical neglect and minimization/denial of abuse are less likely to report higher levels of stress. Childhood experience of physical neglect, emotional abuse, and minimization/denial were significant predictors for perceived social support among university students (β = -.49 to .55, $p > .05$, respectively). The analysis shows that about 13% of changes in perceived social support score are related to the changes in scores of childhood experience of, physical neglect, emotional abuse, and minimization/denial (R^2 = .12). This suggests that students who reported higher scores of physical neglect, emotional and minimization/denial of abuse are less likely to perceive higher levels of social support.

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Table 5.B: Predictors of psychosocial health impact of Jordanian university students with childhood experience of abuse

Outcomes	Predictors	β	R^2	R^2 adjusted	P-value
Depression			.24	.23	<.001
	Physical abuse	.59			<.001
	Sexual abuse	.03			.622
	Emotional abuse	.29			<.001
	Physical neglect	.02			.659
	Emotional neglect	.01			.920
	Minimization/denial	-.30			<.001
Sleep disturbances			.14	.13	<.001
	Physical abuse	.43			<.001
	Sexual abuse	-.04			.389
	Emotional abuse	.15			.081
	Physical neglect	-..5			.191
	Emotional neglect	.02			.754
	Minimization/denial	-.15			<.001
Stress			.06	.05	<.001
	Physical abuse	.35			<.001
	Sexual abuse	.11			.099
	Emotional abuse	-.04			.546
	Physical neglect	-.30			<.001
	Emotional neglect	-.12			.103
	Minimization/denial	-.23			.002
social support			.13	.12	<.001
	Physical abuse	-.14			.178
	Sexual abuse	-.02			.857
	Emotional abuse	-.30			.006
	Physical neglect	-.49			<.001
	Emotional neglect	-.12			.35
	Minimization/denial	.55			<.001

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4.3.1 The relationship between severity of childhood experience of abuse and severity of psychosocial health problems among university students in Jordan

The third question related to the relationship between severity of childhood experience of abuse domains and depression, sleep disturbances, and stress was answered using Pearson product-moment correlation coefficient (r). When asked about severity of childhood experience of physical abuse, 732 (52.2%) of students reported that they had none to minimal levels, 271 (19.4%) reported low to moderate levels, 233 (16.6%) reported moderate to severe levels, and 164 (11.7%) reported that severe to extreme levels. For sexual abuse, 754 (53.9%) of students reported none to minimal levels, 321 (22.9%) reported that low to moderate levels, 228 (16.3 %) reported moderate to severe levels, and 97 (6.9%) reported severe to extreme levels. For emotional abuse, 1274 (91%) of students reported that they had none to minimal levels, 67 (4.8%) reported low to moderate levels, 32 (2.3%) reported moderate to severe levels, and 27 (1.9%) reported severe to extreme levels. For physical neglect, 526 (37.6%) of students reported none to minimal levels, 322 (23) reported that they low to moderate levels, 315 (22.5 %) reported moderate to severe levels, and 237 (16.9) reported severe to extreme levels. For emotional neglect, 983(70.2%) of students reported none to minimal levels, 387 (27.6) reported low to moderate levels, 23 (1.6%) reported moderate to severe levels, and 7 (.5) reported severe to extreme levels (see table 6).

Table 6: Severity of childhood experience of abuse among university students in Jordan

Variable	None to Minimal		Low to Moderate		Moderate to Severe		Severe to Extreme	
	n	%	n	%	n	%	N	%
Physical abuse	732	52.2	271	19.4	233	16.6	164	11.7
Sexual abuse	754	53.9	321	22.9	228	16.3	97	6.9
Emotional abuse	1274	91.0	67	4.8	32	2.3	27	1.9
Physical neglect	526	37.6	322	23.0	315	22.5	237	16.9
Emotional neglect	983	70.2	387	27.6	23	1.6	7	.5

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As shown in Table 7, physical abuse has a positive correlation with depression, sleep disturbances, and stress (r = .43, .35, and .18, respectively) with p value less than .001. This suggests that students who reported high physical abuse scores are more likely to report higher levels of depression, sleep disturbances, and stress. Sexual abuse had a positive correlation with depression, sleep disturbances, and stress (r = .28, p = <.001; .19, p = <.001; and .16, p = <.001, respectively). This suggests that students who reported high sexual abuse are more likely to report high level of depression, sleep disturbances, and stress. Emotional abuse had a positive correlation with depression and sleep disturbances (r = .27, p = <.001 and .17, p = <.001). This suggests that students who reported high emotional abuse scores are more likely to report high level depression and sleep disturbances. Physical neglect had a positive correlation with depression and sleep disturbances (r = .28, p = <.001 and .20, p = <.001). This suggests that students who reported high physical abuse scores are more likely to report high level of depression and sleep disturbances. Emotional neglect had a positive correlation with depression and sleep disturbances (r = .09, p = .001 and .07, p = .008). This may indicate that students who reported high emotional neglect scores are more likely to report high level of depression and sleep disturbances. No significant correlation for physical and emotional neglect with stress.

Physical abuse had a positive correlation with depression, sleep disturbances, and stress (Kendall's tau b = .33, p = <.001; Kendall's tau b = .27, p = <.001; Kendall's tau b = .16, p = <.001, respectively). Level of sexual abuse had a positive correlation with depression, sleep disturbances, and stress (Kendall's tau b = .18, p = <.001; Kendall's tau b = .12, p = <.001; Kendall's tau b = .13, p = <.001, respectively). Level of emotional abuse had a positive correlation with depression, sleep disturbances, and stress (Kendall's tau b = .20, p = <.001; Kendall's tau b = .14, p = <.001; Kendall's tau

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b = .05, p = .023, respectively). Level of physical neglect had a positive correlation with depression and sleep disturbances (Kendall’s tau b = .21, p = <.001 and Kendall’s tau b = .15, p = <.001). Level of emotional neglect had a positive correlation with depression and sleep disturbances (Kendall’s tau b = .08, p = <.001 and Kendall’s tau b = .06, p = .008). In general, this suggests that students exposed to more of childhood experience of physical, sexual, and emotional abuse are more likely to report high level of depression, sleep disturbances, and stress. Moreover, students who reported more physical and emotional neglect are more likely to report high level of depression and sleep disturbances.

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Table 7: Depression, sleep disturbances, stress, physical abuse, sexual abuse and emotional abuse Physical Neglect and Emotional Neglect.

	Depression	Sleep disturbances	Stress	Physical abuse	Sexual abuse	Emotional abuse	Physical neglect	Emotional neglect
Depression	-	.657**	.347(**)	.327(**)	.182(**)	.204(**)	.214(**)	.075(**)
Sleep disturbances		-	.324(**)	.268(**)	.124(**)	.138(**)	.153(**)	.064(**)
Stress			-	.157(**)	.128(**)	.052(*)	.020	-.008
Physical abuse				-	.439(**)	.284(**)	.375(**)	.114(**)
Sexual abuse					-	.259(**)	.274(**)	.118(**)
Emotional abuse						-	.139(**)	.060(*)
Physical neglect							-	.138(**)
Emotional neglect								-

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

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4.4.1 Difference in forms of childhood experience of abuse in relation to selected demographic and personal characteristics

The fourth research question was attempting to detect differences in childhood experience of abuse in relation to demographic variables among the university students in Jordan. ANOVA test was used to test differences in childhood experience of abuse in relation to paternal educational level. The analysis showed that there were significance differences in students experience of physical neglect ($F = 6.63$, $p = <.001$) and minimization/denial domains ($F = 8.58$, $p = <.001$) in relation to their fathers' educational levels (see table 8.A). The post hoc comparison (Tukeys HSD) test showed that a significant difference in physical neglect domains was observed between illiterate (mean = 10.65) and graduate level (mean = 8.30); and between high school and low (mean = 9.55) and graduate level (mean = 8.30). Higher mean scores of physical neglect were observed among illiterate and high school or low education level of father's, while the lowest mean score was observed among fathers with graduate level. This indicates that students whose father's is illiterate or high school level of education are more likely to report childhood physical neglect than students whose father's a graduate level of education. Regarding minimization/denial domains, the post hoc comparison (Tukeys HSD) showed a significant difference between illiterate (mean = 9.53) and high school or low (mean = 10.90), diploma (mean = 11.32), baccalaureates (mean = 11.36), and graduate level; between high school or low (mean = 10.90) and graduate level (mean = 11.63). Higher mean scores of minimization/denial were observed among graduate, baccalaureates, and diploma levels of education. While the lowest mean score was observed among fathers with illiterate, high school or low levels of education. This indicates that student whose father's have diploma, baccalaureates, and graduate level of

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education are more likely to report childhood minimization/denial than students whose father's have illiterate and high school or low levels.

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Table 8.A: Differences between childhood experience of abuse and fathers' educational level among university students in Jordan

Father educational level	Illiterate	High school or low	Diploma	Baccalaureate	Graduate level (Master and PhD)		
	Mean(SD)	Mean(SD)	Mean(SD)	Mean(SD)	Mean(SD)	F	P-value
Physical Abuse	9.11(3.74)	8.39(3.63)	8.05(3.15)	8.15(3.37)	7.90(3.32)	1.81	.125
Sexual Abuse	6,64(3.43)	6.88(3.23)	6.62(2.72)	6.82(2.95)	6.76(3.17)	.28	.890
Emotional Abuse	5.73(1.98)	5.99(2.63)	5.59(1.71)	5.94(2.79)	5.96(2.69)	.85	.491
Physical Neglect	10.65(3.69)	9.65(3.83)	9.35(3.53)	9.19(3.73)	8.30(3.56)	6.63	<.001
Emotional Neglect	9.96(2.67)	9.48(2.17)	9.32(1.95)	9.30(1.77)	9.26(2.09)	1.80	.127
Minimization/Denial	9.53(2.39)	10.90(2.72)	11.32(2.53)	11.36(2.80)	11.63(2.48)	8.58	<.001
Childhood Abuse	51.62(9.60)	51.29(9.56)	50.23(9.56)	50.5(8.94)	49.81(9.28)	1.25	.290

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ANOVA analysis was used to test differences in childhood experience of abuse in relation to mother's level of education. The analysis showed that there were significant differences in participants who reported childhood experiences of physical abuse (F = 3.13, p = .014), emotional abuse (F = 2.46, p = .014), physical neglect (F = 7.42, p = <.001), emotional neglect (F = 6.44, p = <.001), and minimization/denial domains (F = 12.01, p = <.001) except for sexual abuse (F = .89, p = .468) in relation to mothers' educational levels (see table 8.B). The post hoc comparison (Tukeys HSD) test showed that a significant difference in physical abuse domain was observed between illiterate (mean = 9.03) and baccalaureate levels of education (mean = 7.79). This suggests that students whose mother's have illiterate level of education are more likely to report childhood experience of physical abuse than students whose mothers have baccalaureate level of education. Regarding emotional abuse domain, the post hoc comparison (Tukeys HSD) showed a significant difference between students whose mother's having diploma (mean = 5.74) and graduate levels of education (mean = 6.88); and between baccalaureate (mean = 5.73) and graduate (mean = 6.88) levels of education. This suggests that students whose mother's have graduate level of education are more likely to report of childhood experience of emotional abuse than those students mothers with diploma and baccalaureate levels of education. Regarding physical neglect, the post hoc comparison (Tukeys HSD) showed a significant difference between students whose mother's illiterate (mean = 10.42) and diploma (mean = 9.18), baccalaureate (mean = 8.48), and graduate levels of education (mean = 8.69); and between high school or below (mean = 9.55) and baccalaureate level of education (mean = 8.69). This indicates that student whose mother's have illiterate level of education are more likely to report of childhood experience of physical neglect than those students whose mothers have diploma, baccalaureate, and graduate levels of

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education. Also, students who report their mother have high school or below are more likely to report of childhood experience of physical neglect than those students whose mother's have baccalaureate level of education. Regarding emotional neglect, the post hoc comparison (Tukeys HSD) showed a significant difference between students whose mothers with illiterate (mean = 10.01) and diploma (mean = 9.34) and baccalaureate levels of education (mean = 9.03); and between students whose mothers with baccalaureate (mean = 9.03) and graduate levels of education (mean = 10.04). This suggests that those students whose mothers illiterate are more likely to report of childhood experience of emotional neglect than those students whose mothers have diploma and baccalaureate levels of education. Students whose mothers have graduate level of education are more likely to report of childhood experience of emotional neglect than those students whose mothers have baccalaureate level of education. Regarding minimization/denial domains, the post hoc comparison (Tukeys HSD) showed a significant difference between illiterate (mean = 10.09) and high school or below (mean = 10.95), diploma (mean = 11.27), baccalaureates (mean = 11.82), and graduate levels of education (mean = 12.06); between high school or below (mean = 10.95) and baccalaureates (mean = 11.82) and graduate levels of education (mean = 12.06). This suggests that students whose mothers illiterate are less likely to report of minimization/denial than those students whose mothers have high school or below, diploma, baccalaureate, and graduate levels of education. Also, those students whose mothers have graduate degree and baccalaureates level of education are more likely to report of minimization/denial than those students whose mothers have high school or below level of education.

In general, ANOVA test inferred that the major differences in childhood experience of abuse were most observed between those students whose mother illiterate

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(mean = 52.66) and baccalaureate levels of education (mean = 49.49); and between baccalaureate (mean = 49.49) and graduate levels of education (mean = 53.63). This may indicate that students whose high mean score (in mothers' level of education) are more likely to report childhood experience of abuse. In other words, students whose mothers have graduate level of education are more likely to report of childhood experience of abuse than those students whose mothers have other levels of education.

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Table 8.B: Differences between childhood experience of abuse and mother's educational level among university students in Jordan

Mother's educational level	Illiterate	High school or low	Diploma	Baccalaureate	Graduate level (Master and PhD)		
	Mean(SD)	Mean(SD)	Mean(SD)	Mean(SD)	Mean(SD)	F	P-value
Physical Abuse	9.03(3.47)	8.28(3.44)	8.11(3.55)	7.79(3.26)	8.67(4.28)	3.13	.014
Sexual Abuse	7.13(2.59)	6.79(3.06)	6.75(2.95)	6.64(2.82)	7.29(4.23)	.89	.468
Emotional Abuse	5.98(2.59)	5.96(2.65)	5.74(246)	5.73(2.37)	6.88(3.86)	2.46	.014
Physical Neglect	10.42(3.89)	9.55(3.75)	9.18(3.95)	8.48(3.28)	8.69(3.88)	7.42	<.001
Emotional Neglect	10.01(2.33)	9.40(2.09)	9.34(1.77)	9.03(1.79)	10.04(2.81)	6.44	<.001
Minimization/Denial	10.09(2.64)	10.95(2.72)	11.27(2.77)	11.82(2.51)	12.06(2.20)	12.01	<.001
Childhood Abuse	52.66(9.42)	50.93(9.22)	50.39(8.18)	49.49(8.10)	53.63(14.22)	4.15	.002

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Using ANOVA to test differences in childhood experience of abuse in relation to parents' marital status, the analysis showed that there were significant differences in participants' reports of childhood experience of physical abuse (F = 10.03, p = <.001), sexual abuse (F = 5.93, p = .001), physical neglect (F = 13.35, p = <.001), and minimization/denial (F = 11.59, p = <.001) in relation to their parents' marital status except for emotional abuse (F = .48, p = .692) and emotional neglect (F = 1.93, p = .122) (see table 8.C). The post hoc comparison (Tukeys HSD) test showed a significant difference in physical abuse was observed between children of married parents not living together (mean = 11.16), and those children of married parents living together (mean = 8.08), and widowed parents (mean = 8.67). A significant difference was found between children of married parents not living together (mean = 11.16) and widowed parents (mean = 867). Regarding sexual abuse, the post hoc comparison showed a significant difference between children of married parents living together (mean = 6.70), and children of divorced parents (mean = 8.52); and between children of divorced parents (mean = 8.52), and children of widows parents (mean = 7.00). Regarding physical neglect, the post hoc comparison showed a significant difference between children of married parents living together (mean = 9.17), and those of divorced parents (mean = 12.44); and between children of divorced parents (mean = 12.44), and children of widow's parents (mean = 9.32). Regarding minimization/denial domains, the post hoc comparison (Tukeys HSD) showed a significant difference between children of married parents living together (mean = 11.25), and children of married parents not living together (mean = 9.32), and children of divorced parents (mean = 9.38),; between children of married parents not living together (mean = 9.32), and children of widowed parents (mean = 11.03); and between children of divorced parents (mean = 9.38), and children of widowed parents (mean = 11.03).

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In general, ANOVA test inferred that the major's differences in childhood experience of abuse were most observed between children of married parents living together (mean = 50.49) and those children of divorced parents (mean = 56.31); between children of divorced parents (mean = 56.31) and those children of widow's parents (mean = 51.27). Higher mean score in parents' marital status was observed among students whose parents divorced (mean = 56.31). The lowest mean scores were observed among students whose parents married and living together (mean = 50.49) and those students of widow's parents (mean = 51.27). This means those students whose parents are divorced are more likely to report of childhood experience of abuse than those students whose parents are married and living together.

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Table 8.C: Differences between childhood experience of abuse among university students and their parent's marital status

Parent marital status	Married and living together	Married and not living together	Divorced	Widow		
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	F	P value
Physical Abuse	8.08 (8.08)	11.16 (3.06)	9.60 (4.06)	8.67 (8.68)	10.03	<.001
Sexual Abuse	6.70 (6.70)	7.44 (3.04)	8.52 (5.62)	7.00 (2.96)	5.93	.001
Emotional Abuse	5.89 (2.62)	5.92 (1.89)	5.89 (2.62)	5.94 (2.54)	.480	.692
Physical Neglect	9.17 (9.18)	10.92 (4.07)	12.44 (4.68)	9.32 (3.85)	13.53	<.001
Emotional Neglect	9.39 (2.00)	8.96 (2.51)	10.02 (3.05)	9.31 (1.93)	1.93	.122
Minimization/Denial	11.25 (2.60)	9.32 (3.86)	9.38 (2.90)	11.03 (3.04)	11.59	<.001
Childhood Abuse	50.49 (8.84)	53.72 (6.76)	56.31 (15.25)	51.27 (8.41)	7.35	<.001

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Using ANOVA analysis to detect differences in childhood experience of abuse in relation to participants residence during childhood, the analysis showed that there were significant differences in participants reports of childhood experience of physical abuse (F = 7.31, p = <.001), sexual abuse (F = 13.16, p = <.001), physical neglect (F = 5.25, p = <.001), emotional neglect (F = 11.14, p = <.001), and minimization/denial (F = 6.53, p = <.001) with regard to their residence except for emotional abuse domain ((F = 2.33, p = .072) (see table 8.D). The post hoc comparison (Tukeys HSD) test showed a significant difference in physical abuse observed between those who lived in Rural areas (mean = 8.01) and those who lived in Bedouin area (mean = 10.68) and Palestinian camps (mean = 9.59); between those who lived in Urban areas (mean = 10.68) and those who lived in Bedouin area (mean = 10.68). Also, a significant difference was found between those who lived in Palestinian camps (mean = 9.59) and those who lived in Rural areas (mean = 8.01). Regarding sexual abuse, the post hoc comparison test showed a significant difference between those who lived in Rural areas (mean = 6.65) and those who lived in Bedouin area (mean = 9.47) and Palestinian camps (mean = 9.29); and between those who lived in Urban areas (mean = 6.81) and those who lived in Bedouin area (mean = 9.47) and Palestinian camps (mean = 9.29). Regarding physical neglect, the post hoc comparison test showed a significant difference between those who lived in Rural areas (mean = 9.10) and those who lived in Bedwin area (mean = 11.42). Regarding emotional neglect, the post hoc comparison test showed a significant difference between those who lived in Rural areas (mean = 9.26) and those who lived in Bedouin area (mean = 11.00); and between those who lived in Urban areas (mean = 9.50) and those who lived in Bedouin area (mean = 11.00) and Palestinian camps (mean = 10.79). A significant difference was also found between those who lived in Palestinian camps (mean = 10.79) and those who lived in Bedouin

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area (mean = 11.00). Regarding minimization/denial domains, the post hoc comparison (Tukeys HSD) test showed a significant difference between those who lived in Urban areas (mean = 2.70) and those who lived in Rural areas (mean = 11.36). The higher mean scores were observed among student who lived their childhood period in Bedouin and in rural areas which means that students whose lived in Bedouin and rural areas during their childhood period are more likely to report childhood experience of abuse than those students whose lived in urban area.

In general, ANOVA test infers that the most significant differences in childhood experience of abuse (F = 14.14, <.001) were observed between those who lived in rural areas (mean = 50.25) and those who lived in Bedouin area (mean = 60.58) and Palestinian camps (mean = 10.29); between those who lived in Urban area (mean = 51.09) and those who lived in Bedouin area (mean = 60.58) and Palestinian camps (mean = 57.00). Higher mean score in residence of students during childhood period were observed among students whose lived in Bedouin area (mean = 60.58) and Palestinian camps (mean = 10.29).While the lowest mean scores observed among students whose lived in Rural areas (mean = 50.25) and who lived in Urban area (mean = 51.09). This means students who lived in Bedouin area and Palestinian camps are more likely to report of childhood experience of abuse than students whose lived in Rural and Urban area.

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Table 8.D: Differences between childhood experience of abuse and residences among university students in Jordan

Residence	Rural Mean (SD)	Urban Mean (SD)	Bedouin area Mean (SD)	Camps Mean (SD)	F	P value
Physical Abuse	8.01 (3.35)	8.52 (3.54)	10.68 (5.13)	9.59 (3.47)	7.31	<.001
Sexual Abuse	6.65 (2.85)	6.81 (3.04)	9.47 (6.71)	9.29 (4.77)	13.16	<.001
Emotional Abuse	5.87 (2.64)	5.90 (2.42)	7.32 (4.80)	6.41 (2.48)	2.33	.072
Physical Neglect	9.10 (3.69)	9.61 (3.77)	11.42 (4.54)	10.62 (4.31)	5.25	<.001
Emotional Neglect	9.26 (1.92)	9.50 (2.12)	11.00 (3.82)	10.79 (2.48)	11.14	<.001
Minimization/Denial	11.36 (2.70)	2.70 (2.72)	10.68 (2.03)	10.29 (2.55)	6.53	<.001
Childhood Abuse	50.25 (8.61)	51.09 (8.66)	60.58 (20.39)	57.00 (12.98)	14.14	<.001

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ANOVA was used to test differences in childhood experience of abuse in relation to parents living arrangement during childhood among students. The analysis showed that there were significant differences in participants' reports of childhood experience of physical abuse ($F = 9.25$, $p = <.001$), sexual abuse ($F = 9.23$, $p = <.001$) emotional abuse ($F = 6.61$, $p = <.001$), physical neglect ($F = 9.54$, $p = <.001$), emotional neglect ($F = 3.43$, $p = .016$), and minimization/denial ($F = 8.78$, $p = <.001$) in relation to their living arrangement during their childhood (see table 8.E). The post hoc comparison (Tukeys HSD) test showed a significant difference in childhood experience of physical abuse relating to living arrangements during childhood between those who lived with mother (mean = 4.77) and parents (mean = 8.14)and those who lived with another person (mean = 12.14). Regarding sexual abuse, the post hoc (Tukeys HSD) comparison showed a significant difference between those who lived with parents (mean = 6.71) and those who lived with mothers (mean = 7.80) and others (mean = 10.21); and between living with mothers (mean = 7.80) and those who lived with others (mean = 10.21). A significant difference was found between those who lived with others (mean = 7.80) and those who lived with parents (mean = 6.71). Regarding emotional abuse, the post hoc comparison (Tukeys HSD) showed a significant difference between those who lived with mothers (mean = 5.11), father (mean = 8.56), and parents (mean = 5.89), and those who lived with another person (mean = 8.93). Regarding physical neglect, the post hoc comparison (Tukeys HSD) showed a significant difference between those who lived with parents (mean = 9.21) and those who lived with father (mean = 13.33), mother (mean = 10.69), and another person (mean = 12.29). Regarding minimization/denial domains, the post hoc comparison (Tukeys HSD) showed a significant difference between those who lived with father (mean = 8.11) and parents (mean = 11.22). The higher mean scores was observed among students who lived with

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other person (not father or mother) (mean = 63.86) and those who lived with their fathers (mean = 55.78), which means that students who are not living with either parent or with their fathers are more likely to report childhood experience of abuse.

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Table 8.E: Differences between childhood experience of abuse and parents' living arrangement among university students in Jordan

Living	Parents	Father	Mother	Others		
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	F	P- value
Physical Abuse	8.14 (3.39)	10.44 (4.77)	4.77 (3.81)	12.14 (5.22)	9.25	<0.001
Sexual Abuse	6.71 (2.92)	8.56 (5.48)	7.80 (4.012)	10.21 (7.12)	9.23	<0.001
Emotional Abuse	5.89 (2.57)	5.11 (0.33)	5.88 (1.85)	8.93 (6.53)	6.61	<0.001
Physical Neglect	9.21 (3.66)	13.33 (3.50)	10.69 (4.49)	12.29 (5.46)	9.54	<0.001
Emotional Neglect	9.35 (1.99)	10.22 (2.17)	9.86 (2.18)	10.64 (5.11)	3.43	0.016
Minimization/Denial	11.22 (2.67)	8.11 (2.98)	2.977 (3.10)	9.64 (2.06)	8.78	<0.001
Childhood Abuse	50.52 (8.71)	55.78 (10.84)	53.53 (10.06)	63.86 (22.85)	12.93	<0.001

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The question of gender differences in childhood experience of abuse, t- test was used (see table 9). The analysis showed that male and female students differed significantly in reporting childhood physical abuse (t = 1.45, p = .148); male students had a higher mean score than female students (M = 8.40, SD = 3.54, M = 8.13, SD = 3.41, respectively). Regarding sexual abuse, the analysis showed significant differences between male and female students (t = 6.53, DF = 1398, p = <.001); male students had a higher mean score than female students (M = 7.46, SD = 3.50, M = 6.37, SD = 2.70, respectively). Regarding emotional abuse, the analysis showed significant differences between male and female students (t = 3.50, DF = 1398, p = <.001); male students had a higher mean score than female students (M = 6.21, SD = 2.91, M = 6.37, SD = 2.40, respectively). Regarding physical neglect, the analysis showed significant differences between male and female students (t = 1.05, DF = 1398, p = .295); male students had a higher mean score than female students (M = 9.46, SD = 3.83, M = 9.24, SD = 3.70, respectively). Regarding emotional neglect, the analysis showed significant differences between male and female students (t = 3.39, DF = 1398, p = .001); male students had a higher mean score than female students (M = 9.62, SD = 2.24, M = 9.24, SD = 1.90). Regarding minimization/denial, the analysis showed significant differences between male and female students (t = -0.55, DF = 1398, p = .582); female students had higher mean score than male students (M = 11.17, SD = 2.72, M = 11.09, SD = 2.69).

This means that males are more likely to report childhood experience of abuse than females in most of abuse forms except in minimization/denial where females had higher reports than males.

In general, T-test rest infers major significant differences in childhood experience of abuse between males and females (t = 4.79, DF = 1398, p = <.001), with a higher

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mean score for males (52.24; SD = 10.40) than for females (49.87; SD = 8.04). Higher mean score of childhood abuse in relation to gender of students were observed among male students (mean = 52.24).While the lowest mean scores were observed among female students (mean = 49.87). This suggests male students are more likely to report of childhood experience of abuse than female students.

Table.9. Differences between mean score of childhood abuse and gender of university students in Jordan

Gender	Variable	Mean	SD	t-test	df	P value
Physical Abuse						
	Male	8.40	3.54	1.45	1398	.148
	Female	8.13	3.41	1.44	1162	.151
Sexual Abuse						
	Male	7.46	3.50	6.53	1398	<.001
	Female	6.37	2.70	6.21	983.7	<.001
Emotional Abuse						
	Male	6.21	2.91	3.50	1398	<.001
	Female	5.71	2.40	3.36	1027	.001
Physical Neglect						
	Male	9.46	3.83	1.05	1398	.295
	Female	9.24	3.70	1.04	1164	.298
Emotional Neglect						
	Male	9.62	2.24	3.39	1398	.001
	Female	9.24	1.90	3.28	1056	.001
Minimization/Denial						
	Male	11.09	2.69	-0.55	1398	.582
	Female	11.17	2.72	-0.55	1201	.581
Childhood Abuse						
	Male	52.24	10.40	4.79	1398	<.001
	Female	49.87	8.04	4.55	983.8	<.001

Pearson product-moment correlation coefficient (r) was used to assess the relationship between childhood experience of abuse domains and continuous demographical variables (mother age, number of family male children, and number of

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family male children, family rank, and family household income). As shown in table 10, the analysis showed that physical abuse had positively correlated with mother's age ($r = 0.07$, $p < 0.015$), number of male children ($r = .07$, $p < 0.013$), number of female children ($r = .06$, $p < 0.033$), and rank of participant in the family ($r = .09$, $p < 0.001$). A negative correlation was observed between physical abuse and family household income ($r = - .09$, $P < 0.001$). This suggests that higher levels of childhood experience of physical abuse were observed among university students who had older parents, larger family size (male and female), lower family household income, and being an older child. Regarding physical neglect was positively correlated with father's age ($r = .07$, $p < 0.012$), number of male children ($r = .08$, $p < 0.003$) number of female children ($r = .07$, $p < 0.012$), rank of family ($r = .09$, $p < 0.001$), and family income ($r = -0.10$, $P < 0.001$). This means that higher levels of childhood experience of physical neglect were observed among university students who had older fathers, larger family size (male and female), being an older child, and lower family household income. Emotional neglect showed a positive correlation with mother's age ($r = .06$, $p < 0.040$), and rank of family ($r = .07$, $p < 0.015$). This indicates that higher levels of childhood experience of emotional neglect were observed among university students who had older mothers and being an older child. Minimization/denial showed positively correlated with family income ($r = .09$, $p < 0.001$), father's age ($r = -.09$, $p < 0.001$), number of male children ($r = -.11$, $p < 0.001$), number of female children ($r = -.10$, $p < 0.001$), and rank of family ($r = -.10$, $p < 0.001$). This suggests that higher levels of childhood experience of physical neglect were observed among university students who had lower family household income, older fathers, larger family size (male and female), being an older child.

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In general, Pearson product-moment correlation coefficient (r) inferred that childhood experience of abuse was correlated with mother's age ($r = .07$, $p < 0.013$), number of male children ($r = .08$, $p < 0.003$), rank of family ($r = .07$, $p < 0.013$), and family income ($r = -0.07$, $P < 0.005$). This suggests that higher levels of childhood experience of abuse were observed among university students who had older mother, larger family size with male children, being an older child, and lower family household income.

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Table 10: The relationships between childhood experience of abuse and socio-demographic characteristics of university students in Jordan

Variable	Age	Father age	Mother age	Family income	Number of male children	Number of female children	Family rank
Physical abuse	.07*	.05	.07*	-.09**	.07*	.06*	.09**
Sexual abuse	.07**	.04	.05	-.05	.10**	.04	.04
Emotional abuse	.05*	-.00	.03	-.02	.05	-.02	-.01
Physical neglect	.10**	.07*	.05	-.10**	.08**	.07*	.09**
Emotional neglect	.07*	.02	.06*	-.04	.03	.03	.07*
Minimization/ denial	-.12**	-.09**	-.05	.09**	-.11**	-.10**	-.10**
Child abuse experience	.09**	.04	.07*	-.07**	.08**	.03	.07*

* Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).

4.5. Summary

A sample of 1400 universities students in Jordan participated in this study. Results showed that 79.8 % of participants reported emotional abuse, 53.7% of them reported childhood experience of sexual abuse and 27.9% reported childhood experience of physical abuse. The mean age of the students was 21.0 years. Sixty percent (60.1%) of them were females and 39.9% were males. The majority of the participants were enrolled in public universities (67.1%, n = 940), and 32.9% (n = 460) were enrolled in private universities. Results revealed that students reported low to moderate childhood experience of abuse. Results indicated that childhood experience of abuse had a positive correlation with depression, sleep disturbances, and stress; negatively correlated with perceived social support. Pearson correlation indicated that childhood experience of abuse has positive and significant correlation with depression, sleep disturbances, and stress except neglect which had no significant correlation with stress. Results indicated that childhood experience of abuse and psychosocial disorders were influenced by several socio-demographics variables such as, gender which appeared to be a significant variable, as male students reported higher levels of childhood experience of abuse than female students.

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CHAPTER FIVE

5. Discussion

This study aimed to examine the forms of childhood experience of abuse among university students in Jordan, as well as, describing the psychosocial correlates of childhood experience of abuse that include stress, depression symptoms, and sleep disturbance. In addition, the study attempted to investigate the relationship between severity of childhood experience of abuse and the psychosocial disturbances (stress, depression symptoms, and sleep disturbance).

In general, the results showed that experience of childhood abuse is prevalent among university students, and that students were suffering moderate to high levels of depression, stress, and sleep disturbances. In addition, gender appeared to be a significant factor, male students had higher reports of childhood experience of abuse than female students.

5.1 Childhood experience of abuse

Findings of this study showed that university students had low to moderate levels of childhood experience of childhood abuse. The reported levels were higher than those reported in previous international studies (Thombs et al., 2007; Weissbecker et al., 2006; Dong et al., 2004). In regards to forms of abuse, this study found that the most reported form was emotional abuse, while there were considerable reports of physical abuse and minimal ones for physical and emotional neglect. The results indicated that all forms of abuse were reported among university students in Jordan during their childhood period which may contribute to their psychosocial wellness later in life. The results do not agree with reports in previous international studies. For example, Dong et al. (2004) reported that two thirds of participants in their study were exposed to at least one type of childhood abuse. In other studies, one fourth of respondents reported no

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history of childhood abuse (May-Chahal and Cawson, 2005; Machado et al., 2007; Wai Wong et al., 2009). One possible explanation for differences in the reports between this study and the previous ones might be related to methodological issues. This study used self report of childhood experience of abuse, while in the previous studies reports relied on direct investigation or hospital records (May-Chahal and Cawson, 2005; Machado et al., 2007). Also differences might be related to use of different instruments to measure abuse. Moreover, cultural variations in regards to definitions and perception of abuse could also be another possible reason for differences in reports. An important issue is also related to lack of reliable records in Jordan and in the Arab countries for childhood abuse and subsequent follow-up for abused children. Jumaian (2001) maintained that there is a great possibility that subjects did not report all forms of abuse, such as sexual abuse, due to the sensitivity of the topic in the Arab cultures. In this study, sexual abuse investigated and showed that about half of the students reported experience of sexual abuse. These results corresponds with previous national study (Jumaian, 2001), which reported similar levels; however, the sample size of this study was very small (<100 subjects) compared to this current. Sexual abuse is one index of the severity of abuse and correlates with serious psychosocial problems later on life. The high prevalence of sexual abuse in this study is alarming a serious impact on the abused children. It has been reported that sexual abuse is highly correlated with depression, suicide, anxiety disorders and antisocial behaviors ((Bonomi, Cannon, Anderson, Rivara, & Thompson, 2008; Fergusson et al., 2008). This indicates that students who reported experience of sexual abuse during childhood period are at high risk for a number of mental disturbances and are more likely to develop aggressive and reckless behaviors. The figure of sexual abuse in this study shows that Jordanian children are not different from

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those in other cultures, which makes sexual abuse against children a global issue rather than a limited one.

5.2 Psychosocial correlates of childhood experience of abuse.

This is study attempted to determine the psychosocial (depression, sleep disturbance, and stress) correlates of childhood experience of abuse among of university students in Jordan. The results showed that there is a positive association between all forms of childhood experience of abuse and the psychosocial factors, particularly with depression, stress, and sleep disturbances. This indicates that children who are exposed to any form of abuse during the childhood period are more likely to suffer psychosocial disturbances later in life. The results agree with previous international studies, which found that physical abuse had positive association with depression and anxiety disorders (Rohde et al., 2008; Springer et al., 2007). In addition, other studies found that emotional abuse during childhood is connected to mental health problems later in life (Fujiwara et al., 2010; Webb et al., 2007; Jewkes et al., 2010; Wright et al., 2009). The results infer that childhood experience of abuse had significant impact on the children mental health stability later on life that includes a number of mental disturbances. These mental health problems if not treated and managed are more likely to develop more serious mental disorder. These mental health problems may influence on the individual's life at the early adulthood stage (early 20's). Peleikis and colleagues (2004) emphasized this issue and maintained that early psychological care had a positive effect on the mental and psychosocial health of abused children, and may lessen the probability of developing mental health problems later in life.

Regarding sleep disturbances, the results of this study showed that all forms of childhood experience of abuse had a positive association with sleep disturbances. These findings are congruent the findings of other studies (e.g. Jamas et al., 2000) reported

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that children with a history of childhood abuse experienced problems in falling asleep, and awakening in mid-sleep. In addition, studies reported that sleep disturbances are clinically common in patients with childhood experience of abuse who also suffer depressive symptoms. Cambers and Belcki (1998) recruited a sample of university students with childhood experience of abuse and reported that there is an association between childhood experiences of abuse and sleep disturbances and indicated that resilient characteristics did not protect abused students from sleep disturbances.

Regarding stress, this study found that there is a positive association between stress and all forms of childhood experience of abuse. The results are consistent with previous studies. Grassi-Oliveira and Stein (2008) enrolled outpatients from pediatric and gynecology services and found a significant association between emotional abuse and post-traumatic stress disorder symptom. Moreover, Spertus et al. (2003) found that emotional abuse and neglect was associated with high rates of posttraumatic stress disorders, depression, anxiety, and physical symptoms. In conclusion, the present study suggests congruence with international studies, in that exposure to childhood abuse will increase the risk of mental health problems later in life, including depression, stress, and sleep disturbances.

Theoretically, using the transactional model of stress, appraisal, and coping Spaccarelli (1994) supports the fact that stress is an interaction of multiple factors, including personal psychological and physiological, and environmental/ecological influences such as family and culture. Coping with stress depends on personal abilities to utilize coping mechanisms (Spaccarell & Kim, 1995). However, psychological health problems such as anger, aggression, or sexual problems may arise if the victims of childhood abuse could not process crisis appraisal, thus avoiding coping with the stress of abuse, in the absence of sufficient social support. This will consequently influence

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the individual's coping abilities later in life; and therefore, suffer mental health problems such as depression, posttraumatic stress disorder, and dissociation in response to stressors (Bal et al., 2009).

Regarding social support, this study found that childhood experience of abuse had a positive correlation with psychosocial disturbances (depression, stress, and sleep disturbance) and a negative correlation with perceived social support. This indicates that students who experienced childhood abuse and neglect and who perceived higher levels of social support are less likely to report higher rates of psychosocial disturbances. The perception of social support depends mainly on the individual's actual perceived availability of social support, or an appraisal that social support is available in similar stressful situations (Chohen, 1988). Therefore, experiencing and surviving abuse during childhood may result in lowering the level of social support perception, social isolation and a lack of confidence that the social system will provide the social support they need. These results are consistent with previous studies. Adams and Bukowski (2007) found that sexual abuse has a weak association with anxiety among those with high quality mother-child relationships, while those who reported low number of friends and low quality mother-child relationships had the strongest association between child sexual abuse and anxiety disorder. Similarly, Bal et al., (2009) enrolled adolescents from six confidential centers for child abuse and neglect and found no significant association between crisis support and using avoidant coping and internalizing and externalizing symptoms.

In conclusion, survivors of childhood abuse may try to isolate themselves and hide their experience of abuse from friends and potential sources of social support. This leads to gradual lowering of the perception that social support is available to them influencing their interpersonal functioning and reliance on avoidant coping. However,

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using avoidance coping is not effective coping. Using avoidant coping while socially isolated will erode the mental and social stability of the survivor of abuse. Stroud (1999) maintained that at times of exposure to abuse, survivors may suffer mental health problems such as anger, sadness, phobias, and fears. These problems could be resolved if students teaches how to seek and set appropriate social support and perceive of the availability of social support that can enhance their psychological function and coping mechanisms.

5.3. Severity of childhood experience of abuse and psychosocial health problems

The third question of study intends to examine the effect of severity of childhood experience of abuse on psychosocial disturbances (depression, sleep disturbance, and stress) among survivors of childhood abuse in university students. This study found that there is a positive association between severity of childhood experience of physical, sexual, and emotional abuse and the psychosocial factors, particularly with depression, stress, and sleep disturbances. This indicates that children who are exposed to sever childhood experience of abuse are more likely to suffer psychosocial disturbances later in life. The results agree with previous international studies who found that child survivors of emotional abuse and neglect are more likely to have psychosocial disorders in adulthood (Grassi-Oliveira & Stein, 2008; Spertus et al., 2003) and physical and sexual abuse in adulthood (Hetzel & McCanne, 2005; Vallone et al., 2009; Hornor, 2010; Chou et al., 2011). Although previous studies found that childhood abuse influenced the mental and social health of child abuse survivors through behavioral, social, cognitive, and emotional pathways, survivors may also be affected by a combination of two or more of these factors, and may lead to worse health problems later in life (Kendal-Tackett, 2002). The findings of this and of reviewed studies emphasize the significant effects of childhood experience of abuse and

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its severity. In other words, the severity of childhood experience of abuse appears to have a highly significant impact on psychosocial health status during childhood and on mental health status in adulthood. On the other hand, children who have robust friendships and strong mother-child relationships, are able to disclose their experience of child abuse, and simultaneously receive social support, and are able to reduce the effects of traumatic events of abuse than children who have few friendships and weak mother-child relationships (Adams & Bukowski, 2007). This indicates that perceived social support plays a significant role in mediating between severities of child experience of abuse and minimizing the severity of psychosocial health disorders among victims of childhood abuse.

5.4. Childhood experience of abuse and selected demographic characteristics

The fourth research question examined the differences in childhood experience of abuse and the demographic characteristics of students in Jordanian universities. This study examined whether differences existed between male and female university students. The results indicate that male university students are more exposed to childhood experience of abuse than female university students. These findings are comparable to other studies', which found that boys reported childhood experience of abuse more than girls (Mathur et al., 2009). However, the findings of this study are incongruent with other reports from previous international studies (e.g. Maikovich-Fong & Jaffee, 2010; Moore et al., 2010), which reported that females were more exposed to childhood experience of abuse than males. In addition, other previous studies found that disclosing of abuse was higher for girls than for boys, and that boys were less likely to disclose abuse. One possible explanation for differences in of the findings of this study and the findings of other studies might be related to differences between cultures of participants regard perceptions, definitions of abuse, discloser of abuse, and differences

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in type of abuse selected in studies. Moreover, there is a great possibility; according to Elebduor et al. (2006), that disclosure of child abuse to another person is more difficult for female victims, especially in Arab culture. In contrast with western culture, in Arab culture, females are loathed to express shameful life events such as child abuse, especially sexual. Sex generally is a taboo subject in the Arab world, and the great value placed on the honor of women inhibits open discussion and disclosure of the abuse of women generally.

With regard to family household income, the results of this study found a significant negative correlation between monthly household income and childhood experience of abuse. This indicates that poorer university students are more likely to have higher childhood experiences of abuse. This result corroborated previous international studies, which found that family household income had a negative association with childhood experience of abuse (Machado et al., 2007; Berger, 2004; Alexandre et al., 2010). In addition, other previous studies showed that poorer families of children are times likely to abuse their children than more financially stable children of families (Sedlak et al., 2010). Findings of this study indicate that among university students in Jordan, the socioeconomic status of families may have a significant role in exposure to childhood abuse; there is a major correlation between low socioeconomic status of families and higher occurrence of childhood abuse. This result may explained by the fact child abuse could be higher among families of low socioeconomic status and this may be related to shortage in the main demands of children development; less educated parents, large number of children, and thus struggle to meet the needs of children.

The results of this study showed that there is an association between students' residence and childhood experience of abuse. This finding is consistent with the

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findings of Elbedour et al. (2006). They noted that girls in Palestinian Bedouin communities are more likely to experience childhood sexual abuse than other residential communities. The reported rate of childhood experience of abuse was higher among students living in Bedouin area than in Palestinian refugee camps, and the lowest levels were in rural areas. This indicates that students who lived in Bedouin area and Palestinian refugee camps are more likely to be exposed to childhood abuse than other students in urban and rural areas. On other hand, the current study provides evidence-based data that child abuse represents a serious social problem within the Bedouin area and Palestinian refugee camps, and a high proportion of adolescents who dwell there are at risk of being abused. The results of this study indicate that residence place can effect on occurrence of childhood experiences of abuse among university students'. Elbedour & other focused on some areas and used small samples (n = 217) of females, as well as different measurements from this study, which included respondents from all population division. Also, the results of this study suggest that students who live in urban areas reported childhood experience of abuse more than those in rural areas. However, the findings of this study do not agree with reports from previous international studies. For example, Sedlak et al. (2010) reported in NIS-4 that the incident rate of child abuse in rural areas is 10.4 per 1000, and 6.4 children per 1000 in urban areas; this means that child abuse in the former is 1.7 times greater than in the latter. The differences may be related to the different definition of childhood abuse victims in this study. Sedlak et al. studied different subjects from different cultures in which records of survival and perception of abuse are different.

This study showed that there were significant differences in childhood experience of abuse between different parents living arrangements. These findings are congruent with the findings of other studies (Sedlak et al., 2010; Alexandre et al., 2010),

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which reported that children living with both married biological parents had a significantly lower rate of child abuse than those who living with a single parent or with other persons. Also they showed that the highest rate of child abuse occurred for children living with people not from their family. In addition, Berger (2004) found that children living with both biological parents were less likely to have had a risk of health problems and child abuse, and also that those children living with a single parent were more at risk of health problems and child abuse. The findings of this study indicate that the highest rate of childhood abuse occurs among students who lived with a person other than their biological parents, and the lowest rate was for those living with both biological parents. One explanation for this finding could be that some behaviors are considered socially acceptable from caregivers, especially parents, as legitimate disciplinary methods, which are considered abuse in other contexts (Khalaf et al., 2006; May-Chahal & Cawsonb, 2005; Elebduor et al., 2006). Another possible explanation is that both parents love their children and try to provide optimum care and facilities for them (Malik, 2010). This indicates that family structure plays an important role in protecting children from events such as child abuse.

Regarding parents' level of education, the results of this study showed that there is no significant relationship between the father's education level and childhood abuse and among university students in Jordan. As described in the results, this is consistent with findings found in other studies (e.g. Alokan & Kemi, 2010), which found that there is no relationship between the education level of fathers and childhood abuse among school students. The result of this study suggested that fathers' educational levels were not different in five domains of childhood abuse. This indicates that father levels of educational if illiterate or educated may not affect child abuse occurrence. However, the findings are consistent with a growing body of knowledge on the effect of the maternal

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educational level on childhood abuse. Machado et al. (2007) and Shojaeizadeh (2001) found that there was an association between low educational level of parents and socio-economic status (identified as a factor in child abuse above). The findings of this study indicate that maternal educational level may have an effect on the occurrence of child abuse. The study indicates that students whose mothers have a low level of education are more likely to report childhood experience of abuse. This result may be explained by the fact that child abuse is precipitated by a number of triggers. One of these could be related shortage in the main demands of children; less educated parents typically have lower socio-economic status, and thus struggle to meet the needs of children. Another explanation is that less educated mothers have physically stressful and emotionally demanding lifestyles, which may contribute to abuse. All of these factors can influence the intimacy of child-mother relationships and healthcare relations (Shojaeizadeh D., 2001).

In conclusion, certain demographic and personal characteristics are associated with the phenomenon of child abuse. Socio-demographic variables such as gender, socioeconomic status (mainly household income), residence, parents' education levels, and living arrangements have been associated with child abuse in this study. Those most at risk are typically male, from families with low household income of Bedouin area, have mothers of a lower educational level, and live with a single parent or a non-family person. Some findings of this study differ from those of western studies, reflecting different cultural and social norms, and family life and roles.

5.5. Implications of the study

Findings of this study add to a growing body of knowledge regarding the prevalence and forms of childhood experience of abuse and it is impact on the psychosocial health status of Jordanian university students, giving a foundation for the

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development of evidence-based practices to assess, prevent, and treat the phenomena of childhood abuse and it is consequences. The findings support the existence of relationships between childhood abuse and psychosocial health problems, and to support to the importance of assessment of short- and long-term impacts of childhood abuse among adolescent victims.

5.5.1. Implications for practice

The current study indicates that more than two thirds of the students in this study reported at least one type of childhood experience of abuse. Also, the finding of this study revealed that there is association between childhood experience of abuse and psychosocial health disorders among students. The findings suggest that young adults at university age need effective mental and psychosocial health care programs that encompass their psychosocial need and consider their lived experience. The consequences of abuse interfere with students' psychological development and their social and community performance. This may result in increasing risk of mental and psychosocial disturbances.

On the other hand, there is a need to reconsider the education system preparedness for receiving students who may have history of psychosocial problems such as experience of abuse. Counseling units are needed to provide mental and psychosocial counseling and there should be a routine mental health care screening for student upon admission to the universities to identify student at high risk for psychosocial disturbances. Health professionals should also consider psychological screening each time a student visit the outpatient department for physical or bio-psychosocial problem. This screening should include childhood experience of abuse and the psychological status.

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Health care providers and workers everywhere need to learn how to do screening for presence of childhood abuse cases. Therefore an implication of study is to stress the importance of establishing effective programs in schools and universities to screen and follow cases of childhood abuse and providing appropriate community health care for them through assessment, counseling and treatment for victims especially for those who report childhood experience of abuse and psychosocial health disorders by specialist personnel in mental health and illness. Collaboration between health personnel, social workers, teachers, and families should be enhanced to overcome childhood abuse through identifying cases of child abuse and providing support and care for victims.

5.5.2. Implications for education

Jordanian universities can play an important role in preventing, reducing the long term impact of abuse on students and intervening in childhood abuse through the process of developing education programs to prepare faculty members to play a significant role in childhood abuse screening, prevention, and counseling. Students who show visible signs and symptoms of psychosocial health disorders (depression, stress, or anxiety) should be referred for further assessment. These signs and symptoms could affect their health, education, and productivity which may probably last a lifetime if untreated. Also, these programs may encourage students to disclose their childhood experience of abuse and seek help. Moreover, educational programs in universities need to focus on educating students and faculty members how to identify cases of survivals of abuse and the effect of childhood abuse on the survivor's performance and educational achievements.

Findings of this study should be incorporated in nursing curricula to teach nurses about childhood experience of abuse and its effect on psychosocial health of victims of

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childhood abuse. Mental health and illness, community, and pediatric nursing courses and programs should be designed to include materials regarding childhood experience of abuse and psychosocial health disorders. Contents of these courses or programs can include information on how victims' perceive and view themselves and their lives after this traumatic event of childhood abuse, and the influence of health care providers on improving psychological status for them. Furthermore content may include a discussion on supportive nursing interventions and strategies that could be implemented to empower victims; in reducing the severity of childhood experience impact among victims'.

The development of the nursing role has the potential to address numerous health issues, including problems related to child abuse within communities, the treatment of victims of child abuse, responsibility as the development of community health education programs, and evaluation of the effective of possible solution or interventions may be needed. Although, nurses have a role in increasing awareness of parents on the short and long term impact of abuse on mental health of their children. In addition, health personnel have a role in teaching and training social workers, teachers, and parents in how to deal with cases of child abuse to prevent long term consequences of childhood abuse.

5.5.3 Implications for research

This study has shed some light on childhood experience of abuse and its negative health outcome. It is imperative that research expand upon this knowledge. The current study findings gave an important growing body of knowledge on the university student's childhood experience of abuse and great numbers of abuse were associated with increasing levels psychosocial health disorders. Further, increasing severity of childhood experience of abuse was associated with more psychosocial health

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disorders. These findings suggest that there is a need for further research into children and their families and perpetrators to enhance the understanding of the reality of child abuse in Jordan. Further, longitudinal studies that can follow child abuse survivors from time of traumatic events of abuse in childhood into adulthood can enhance the causative relationship between childhood abuse and psychosocial health disorders.

5.5.4 Implications for policy

The findings of this study may be adopted by academic, official, and social institutions to put in place approaches to screen and follow up cases of childhood abuse in Jordan. Nurses are in a key position to develop and coordinate programs regarding childhood abuse to the students in the school and universities as well as to the social workers and students; affaires who interact with students'

5.5.5 Limitations

This study has some limitations, particularly in its use of retrospective self-reporting of childhood experiences of abuse, and convenience sampling in recruiting volunteer participants. Additionally, the population sample of this study was limited to university students. University students normally relatively homogenous in terms of age, educational level, and culture. The accuracy of student reports may be low, depending on students' memory and willingness to report the events of child abuse, and it is possible that some students were uncomfortable in recalling or sharing their traumatic memories of abuse even if they had not forgotten them. However, there is several strengths of this study. Firstly, a quantitative approach was used to explore the phenomena of child abuse, and there were a lot of strengths in using this approach, for example the large sample size of 1400 students, including both male and female students, which enhances the generalizability of findings for university students in the Arab world, especially in Jordan. Also, the main strength of cross-sectional design is

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that it protected the study against bias by linking between conceptual and operational definitions of study variables, selection of sample and sample size, validity and reliability of instruments, data collection procedures, and the achievement of some environmental control. In addition, previous studies focused on only one or two forms of child abuse, especially when examining the impact of child abuse on psychosocial health status. This study was designed to address this gap by using all forms of childhood abuse to clarify the affect of victimization, and to explore other factors can effect on abuse and the relation between abuse and psychosocial disorders.

5.6. Recommendations

- Other longitudinal studies could be conduced to follow child abuse survivors from time of traumatic events of abuse into adulthood to explore the relationship between childhood experience of abuse and later negative health outcomes as psychosocial health disorders.
- Victims of childhood abuse who had psychosocial health disorders should be treated either with face-to-face intervention or online intervention using technological advances such as smart phones and dashboards.
- Screening for survivors of childhood abuse who have psychosocial health disorders and referring them to specialist personnel in mental health and illness.
- The results of this study should be used by policymakers to initiate the first steps toward the construction of psycho-behavioral clinics in the major schools and universities including policies around parenting.
- The results of this study could be disseminated educators, nurses and physicians to familiarize them with the most prevalent problems faced by Jordanian students.
- The results of this study should be communicated to students, to encourage them to express their feelings and to help them in deciding to seek help.

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- There is an urgent need to provide school and university students with educational material in Arabic, to educate them about the importance of child abuse disclosure, its solutions, and it is complications if unchecked.
- There is urgent need for a curriculum based on existing material and models for training health personnel, social workers, teachers, and family members on how to deal with survivors and how to reduce from effect of traumatic event on survivors of abuse.
- The results of this study should be communicated to all personnel working with children, to familiarize them about childhood abuse issue that faced by Jordanian children.
- Further studies regarding sexual abuse that may include qualitative and quantitative approaches of investigating different forms of sexual abuse.
- Establish counseling unites for families to support children and to give those solutions and where to get help and support to talk and not to be silent.
- Increase awareness to parents to try there best to keep the children in the same house with both parents, to seek help when poor to cope with their socioeconomic level to avoid abusing of children, to encourage women to have more education.

5.7. Conclusion

According to this sample of Jordan universities students, the study findings confirm those of existing research; students reported that they had childhood experience of abuse, and the most common form reported was childhood emotional abuse. The study also confirmed that psychosocial health disorders are correlated with childhood experience of abuse. While this association was found across genders, living arrangements, and household income, the strongest associations were among males, and in families with low household incomes, and for students living with a person other than

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their biological parents. The results also suggest that those who report severe childhood experience of abuse are at higher risk of severe psychosocial health disorders.

The present study showed that perceived social support can play a role in the mediating of childhood abuse and it is impact on severe psychosocial health status. From this study and others reviewed within it, it is clear that socio-demographic and personal variables play a role in the occurrence of childhood abuse and inducing its negative outcomes. Childhood abuse and its related negative outcomes will increase if institutions of several kinds do not collaborate to develop strategies and comprehensive plans to prevent further child abuse cases.

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Appendix

عزيزي المشارك:

أنا الطالب سامي الشناق طالب دكتوراه في الجامعة الأردنية. ارغب في إجراء دراسة "تجربة اساءه الطفولة وأثرها في مرحلتي الطفولة المبكرة والمراهقة بين طلبه المرحلة الأولى الجامعية".

عنوان الدراسة: العلاقة بين سوء المعاملة في مرحلة الطفولة والآثار النفسية و الاجتماعية المترتبة عليها عند طلبة الجامعات الأردنية.

عزيزي المشارك كلي أمل أن تساهم نتائج هذا البحث في التعرف على حالات الاساءه للطفولة والاثار المترتبة عليها وكذلك تحسين الرعاية الصحية المقدمة لهم. بناء على ذلك أرجو منك إعطاءنا بعضا من وقتك لملئ الاستبيان بعد قراءة التعليمات. ولكي تجيب على الاستبيان ارجو وضع إشارة× أو دائرة °عند الرقم الذي يعكس بإجابتك.

عزيزي المشارك في حال موافقتك على تعبئة الاستبيان أرجو منك الإجابة عن جميع الأسئلة. كما أرجو وضع الاستبيان بعد ملئة في الظرف المزود لهذا الغرض والتأكد من إغلاقه وإعطاءه للباحث شخصيا.

أن مشاركتكم في هذا البحث اختياريه وبدون مقابل وانك تستطيع الانسحاب من الدراسة في أي وقت, وان جميع الإجابات ستكون سرية, كما تعهد الباحث بالمحافظة على خصوصيتك حيث لا يتطلب الاستبيان ذكر الاسم أو شيء يدل على المشارك. كما يؤكد الباحث أن جميع الاستبيانات سيتم فتحها من قبل الباحث فقط.

عزيزي المشارك رجاء وجه أي تسأل يمكن أن يساعدك في الإجابة على الاستبيان أو عن الدراسة ككل, وفي حال عدم وجودي يمكنك الأتصال بي

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عزيزي المشارك الشكر الجزيل لمشاركتك القيمة.

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Appendix A

Appendix A: Socio-demographic Data Sheet (Arabic version)

الجنس: □ ذكر □ أنثى

العمر:..............................عام

الحالة الزواجية : □ اعزب □ متزوج □ مطلق □ ارمل

الديانة: □ الاسلام □ المسيحيه □ اخرى

الجامعة:...................... **الكلية**.......................... **السنة**.............

عمر الأب:.........................عام

عمر الام: ....عام

المستوى التعليمي للاب: □غيرمتعلم □ اقل من ثانويه عامه □ ثانوية عامة

□ بكالوريوس □ ماجستير □ دبلوم

□ دكتوراه

المستوى التعليمي للام: □غيرمتعلمه □ اقل من ثانوية عامه □ ثانوية عامة

□ بكالوريوس □ ماجستير □ دبلوم

□ دكتوراه

الدخل الشهري للاسره: ....دينار

الحالة الزواجية للوالدين: □متزوجين متصلين □ مطلقين

□ متزوجين غير متصلين □ ارمل \ ارملة

عدد أفراد الاسره: ذكر:.......................

:أنثى.......................

ترتيبك الأسري:...............................

عشت طفولتك مع: □ والديك □ والدك □ والدتك □ مع أشخاص غير والديك

مكان السكن: □ مدينه □ قريه □ باديه □ مخيم

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Appendix B

Childhood Trauma Questionnaire-short form

When I was growing up ...	Never True	Rarely True	Sometimes True	Often True	Very Often True
1. I didn't have enough to eat.	1	2	3	4	5
2. I knew there was someone to take care of me and protect me.	1	2	3	4	5
3. People in my family called me things like "stupid", "lazy", or "ugly".	1	2	3	4	5
4. My parents were too drunk or high to take care of the family.	1	2	3	4	5
5. There was someone in my family who helped me feel important or special.	1	2	3	4	5
6. I had to wear dirty clothes.	1	2	3	4	5
7. I felt loved.	1	2	3	4	5
8. I thought that my parents wished I had never been born.	1	2	3	4	5
9. I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.	1	2	3	4	5
10. There was nothing I wanted to change about my family.	1	2	3	4	5
11. People in my family hit me so hard that it left me with bruises or marks.	1	2	3	4	5
12. I was punished with a belt, a board, a cord, or some other hard object.	1	2	3	4	5
13. People in my family looked out for each other.	1	2	3	4	5
14. People in my family said hurtful or insulting things to me.	1	2	3	4	5
15. I believe that I was physically abused.	1	2	3	4	5

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16. I had the perfect childhood.	1	2	3	4	5
17. I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or doctor.	1	2	3	4	5
18. I felt that someone in my family hated me.	1	2	3	4	5
When I was growing up, ...	**Never True**	**Rarely True**	**Sometimes True**	**Often True**	**Very Often True**
19. People in my family felt close to each other.					
20. Someone tried to touch me in a sexual way, or tried to make me touch them.	1	2	3	4	5
21. Someone threatened to hurt me or tell lies about me unless I did something sexual with them.	1	2	3	4	5
22. I had the best family in the world.	1	2	3	4	5
23. Someone tried to make me do sexual things or watch sexual things.	1	2	3	4	5
24. Someone molested me.	1	2	3	4	5
25. I believe that I was emotionally abused.	1	2	3	4	5
26. There was someone to take me to the doctor if I needed it.	1	2	3	4	5
27. I believe that I was sexually abused.	1	2	3	4	5
28. My family was a source of strength and support.	1	2	3	4	5

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Appendix C

استمارة إساءة الطفولة

عندما كنت في فترة الطفوله	ابدا غير صحيح	نادرا ما يكون صحيح	بعض الاوقات صحيح	غالبا صحيح	دأئما صحيح
1.لم أكن أملك ما يكفي لكي آكل	1	2	3	4	5
2. كنت أعلم أن هناك شخص ما يعتني بي ويحميني	1	2	3	4	5
3.هناك أشخاص في العائلة كانوا ينعتوني بالغبي, الكسول أو البشع	1	2	3	4	5
4. والداي كانا ثملين جدا(سكرين) وغير مهتمين للعناية بالعائلة	1	2	3	4	5
5.كان هناك شخص في العائلة ساعدني لكي أشعر بأني مهم أو مميز	1	2	3	4	5
6. كان علي ان البس ملابس غير نظيفه	1	2	3	4	5
7.كنت اشعر أني محبوب	1	2	3	4	5
8. كنت افكر ان والداي كانا يتمنون اني لم أولد	1	2	3	4	5
9.ضربت بقوة من قبل احد افراد العائلة والذي استدعى رؤية الطبيب او الذهاب للمستشفى	1	2	3	4	5
10. لا يوجد شيء اردت ان اغيره في عائلتي	1	2	3	4	5
11. أناس في عائلتي ضربوني بقسوه والذي ترك آثار وكدمات على جسدي	1	2	3	4	5

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12. عوقبت بالضرب بالحزام, العصى, السلك او أي شيء آخر صلب	1	2	3	4	5
13. اعتنى افراد عائلتي ببعضهم البعض	1	2	3	4	5
14. بعض افراد العائله قالوا لي أشياء مؤذية أو وقحه	1	2	3	4	5
15. اعتقد أني تعرضت للايذاء الجسدي	1	2	3	4	5
16. كان لي طفولة رائعة	1	2	3	4	5
17. ضربت وأذيت بعنف والذي لاحظة المعلم, الجار أو الطبيب	1	2	3	4	5
18. شعرت ان احد افراد العائلة كان يكرهني	1	2	3	4	5
19. أفراد في عائلتي كانوا قريبين بعلاقتهم من بعضهم البعض	1	2	3	4	5
20. أحد ما حاول ان يلمسني بطريقة جنسيه أو جعلني المسه	1	2	3	4	5
21. اناس هددوا بايذائي او بنشر الكذب عني الا اذا مارست الجنس معهم	1	2	3	4	5
22.كان لدي افضل عائلة في العالم	1	2	3	4	5
23. احد ما جعلني اعمل بعض امور جنسية او مراقبة بعض حركات جنسية	1	2	3	4	5
24. احد ما اعتدى علي جنسيا"	1	2	3	4	5
25. اعتقد اني اوذيت عاطفيا" 26. كان هناك شخص ما يأخذني الى الطبيب وقت الحاجة	1	2	3	4	5

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5	4	3	2	1	27. اعتقد أني اوذيت جنسيا"
5	4	3	2	1	28. عائلتي كانت مصدر القو ة والدعم لي

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Appendix D

Trauma Symptom Checklist - 40 (TSC-40)

How often have you experienced each of the following in the last two months?

0 = Never 3 = Often

1. Insomnia (trouble getting to sleep)	0 1 2 3
2. Weight loss (without dieting)	0 1 2 3
3. Restless sleep	0 1 2 3
4. Low sex drive	0 1 2 3
5. Nightmares	0 1 2 3
6. Sadness	0 1 2 3
7. Waking up early in the morning and can't get back to sleep	0 1 2 3
8. Uncontrollable crying	0 1 2 3
9. Not feeling rested in the morning	0 1 2 3
10. Desire to physically hurt yourself	0 1 2 3
11. Waking up in the middle of the night	0 1 2 3
12. Feelings of inferiority	0 1 2 3
13. Feelings of guilt	0 1 2 3

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Appendix E

استمارة أعراض إساءة الطفولة

إرشادات: عزيزي المشارك كم مرة تكرر شعورك للأعراض التالية في الشهرين الماضيين؟ الرجاء وضع دائرة حول الرقم الذي يصف شعورك. مع العلم إنا رقم 0= قطعيا غير صحيح, 1=نادرا ما يكون صحيح, 2=بعض الأوقات صحيح, 3=غالبا صحيح.
الرجاء اجابه الاسئله جميعها بكل أمانه ممكنه بالرغم من طبيعتها الشخصية

الفقـــــــــــــــــــــــــــرة	غير صحيح	ما يكون صحيح	الأوقات صحيح	صحيح
1. خلال الشهرين الماضيين, شعرت بالأرق (صعوبة في الحصول على النوم)	0	1	2	3
2. خلال الشهرين الماضيين, شعرت بفقدان الوزن (دون إتباع نظام غذائي)	0	1	2	3
3. خلال الشهرين الماضيين, شعرت بالنوم المضطرب	0	1	2	3
4. خلال الشهرين الماضيين, شعرت بانخفاض الدافع الجنسي	0	1	2	3
5. خلال الشهرين الماضيين, شعرت بكوابيس	0	1	2	3
6. خلال الشهرين الماضيين, شعرت بالحزن	0	1	2	3
7. خلال الشهرين الماضيين, شعرت بالاستيقاظ في الصباح الباكر وعدم القدرة للعودة إلى النوم	0	1	2	3
8. خلال الشهرين الماضيين, شعرت بعدم السيطرة على البكاء	0	1	2	3
9. خلال الشهرين الماضيين, شعرت بعدم الراحة في الصباح	0	1	2	3

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3	2	1	0	10. خلال الشهرين الماضيين, شعرت بالرغبة في إيذاء نفسك جسديا
3	2	1	0	11. خلال الشهرين الماضيين, شعرت بالاستيقاظ في منتصف الليل
3	2	1	0	12. خلال الشهرين الماضيين, شعرت بالنقص
3	2	1	0	13. خلال الشهرين الماضيين, شعرت بالذنب

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Appendix F

Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you will be asked to indicate by circling *how often* you felt or thought a certain way.

Name

____

Date _________

Age ________ Gender (*Circle*): **M F** Other ____________

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?

…………………………………………………………………………….......... **0 1 2 3 4**

2. In the last month, how often have you felt that you were unable to control the important things in your life?

…………………………………………………………………………….......... **0 1 2 3 4**

3. In the last month, how often have you felt nervous and "stressed"?

…………………………………………………………………………….......... **0 1 2 3 4**

4. In the last month, how often have you felt confident about your ability to handle your personal problems?

…………………………………………………………………………….......... **0 1 2 3 4**

5. In the last month, how often have you felt that things were going your way?

…………………………………………………………………………….......... **0 1 2 3 4**

6. In the last month, how often have you found that you could not cope with all the things that you had to do?

…………………………………………………………………………….......... **0 1 2 3 4**

7. In the last month, how often have you been able to control irritations in your life?

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…………………………………………………………………………….............. **0 1 2 3 4**

8. In the last month, how often have you felt that you were on top of things?

…………………………………………………………………………….............. **0 1 2 3 4**

9. In the last month, how often have you been angered because of things that were outside of your control?

…………………………………………………………………………….............. **0 1 2 3 4**

10. In the last month, how often have you felt that difficulties were piling up so high that you could not overcome them?

…………………………………………………………………………….............. **0 1 2 3 4**

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Appendix G

مقياس الضغط النفسي المدرك

إرشادات: عزيزي المشارك الأسئلة التالية تتعلق بمشاعرك وأفكارك خلال الشهر الماضي.
مقابل كل فقرة ضع إشارة دائرة حول الرقم للتكرار المناسب لعدد المرات التي شعرت وفكرت بها. مع العلم إنا رقم 1=**أبدا,2= تقريبا أحيانا ,3=أحيانا,4= تقريبا في الغالب,5 =غالبا.**

الفقـــــــــــــــــــــــــرة	أبداً	تقريباً أحياناً	أحياناً	تقريباً في الغالب	غالباً
1. خلال الشهر الماضي، كم مرة شعرت بالانزعاج بسبب شيء ما حدث بشكل غير متوقع	1	2	3	4	5
2. خلال الشهر الماضي، كم مرة شعرت بأنك غير قادر على السيطرة على أشياء مهمة في حياتك	1	2	3	4	5
3. خلال الشهر الماضي، كم مرة شعرت بأنك عصبي ومضغوط نفسياً	1	2	3	4	5
4. خلال الشهر الماضي، كم مرة شعرت بأنك تثق بقدرتك على حل مشاكلك الخاصة	1	2	3	4	5
5. خلال الشهر الماضي، كم مرة شعرت بأن الأمور تسير على حسب ما تريد	1	2	3	4	5
6. خلال الشهر الماضي، كم مرة وجدت أنك غير قادر على التكييف مع كل الأشياء المطلوب منك إنجازها	1	2	3	4	5
7. خلال الشهر الماضي، كم مرة كنت قادراً على السيطرة على أشياء تنرفزك في حياتك	1	2	3	4	5
8. خلال الشهر الماضي، كم مرة شعرت بأنك متمكن من الأشياء حولك	1	2	3	4	5
9. خلال الشهر الماضي، كم مرة غضبت بسبب أشياء خارجة عن إرادتك	1	2	3	4	5
10. خلال الشهر الماضي، كم مرة شعرت بأن المصاعب تزداد وأنك لا تستطيع التغلب عليها	1	2	3	4	5

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Appendix H

Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**
Circle the "2" if you **Strongly Disagree**
Circle the "3" if you **Mildly Disagree**
Circle the "4" if you are **Neutral**
Circle the "5" if you **Mildly Agree**
Circle the "6" if you **Strongly Agree**
Circle the "7" if you **Very Strongly Agree**

1.	There is a special person who is around when I am in need.	1	2	3	4	5	6	7	SO
2.	There is a special person with whom I can share my joys and sorrows.	1	2	3	4	5	6	7	SO
3.	My family really tries to help me.	1	2	3	4	5	6	7	Fam
4.	I get the emotional help and support I need from my family.	1	2	3	4	5	6	7	Fam
5.	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7	SO
6.	My friends really try to help me.	1	2	3	4	5	6	7	Fri
7.	I can count on my friends when things go wrong.	1	2	3	4	5	6	7	Fri
8.	I can talk about my problems with my family.	1	2	3	4	5	6	7	Fam
9.	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7	Fri
10.	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7	SO
11.	My family is willing to help me make decisions.	1	2	3	4	5	6	7	Fam
12.	I can talk about my problems with my friends.	1	2	3	4	5	6	7	Fri

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Appendix I

مقياس الدعم الاجتماعي المدرك

إرشادات: عزيزي المشارك الرجاء قراءة العبارات التالية وتحديد إلى أي حد توافق من خلال اختيار الأرقام التالية بوضع دائرة حول الرقم**المناسب.**

الرقم	العبارات	أعارض بشدة						أوافق بشدة
1	إن هناك شخص معين يكون بجانبي عند الحاجة	1	2	3	4	5	6	7
1								
2	إن هناك شخص معين استطيع أن أشاركه أفراحي و أحزاني	1	2	3	4	5	6	7
2								
3	إن عائلتي تحاول أن تساعدني	1	2	3	4	5	6	7
4	احصل على الدعم العاطفي و المساعدة التي احتاجها من عائلتي	1	2	3	4	5	6	7
5	يوجد عندي شخص معين يعتبر المصدر الأساسي لتقديم الراحة لي	1	2	3	4	5	6	7
6	أصدقائي يحاولون تقديم المساعدة لي	1	2	3	4	5	6	7
7	ارتكز و الجأ إلى أصدقائي عند حدوث	1	2	3	4	5	6	7

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	مشاكل							
8	استطيع التحدث مع عائلتي عن مشاكلي	1	2	3	4	5	6	7
9	لدي أصدقاء استطيع أن أشاركهم أفراحي و أحزاني	1	2	3	4	5	6	7
10	إن هناك شخص معين في حياتي يهتم بمشاعري	1	2	3	4	5	6	7
11	عائلتي لديها الاستعداد لمساعدتي في اتخاذ قراراتي	1	2	3	4	5	6	7
12	استطيع التحدث مع أصدقائي عن مشاكلي	1	2	3	4	5	6	7

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Appendix J

Table 3.A: Childhood experience of abuse among University Students in Jordan (N=1400)

Item	Never True		Rarely True		Sometimes True		Often True		Very Often True			
	N	%	n	%	n	%	n	%	N	%	M	SD
1. I didn't have enough to eat.	1237	88.4	81	5.8	48	3.4	14	1.0	20	1.4	1.21	0.68
2. I knew there was someone to take care of me and protect me.	130	9.3	29	2.1	58	4.1	202	14.4	981	70.1	4.34	1.24
3. People in my family called me things like "stupid", "lazy", or "ugly".	898	64.1	253	18.1	170	12.1	54	3.9	25	1.8	1.61	0.96
4. My parents were too drunk or high to take care of the family.	1259	89.9	66	4.7	39	2.8	15	1.1	21	1.5	1.20	0.68
5. There was someone in my family who helped me feel important or special	88	6.3	122	8.7	216	15.4	406	29.0	568	40.6	3.89	1.21
6. I had to wear dirty clothes	1291	92.2	64	6.4	21	1.5	9	0.6	15	1.1	1.14	0.56
7. I felt loved	50	3.6	66	4.7	205	14.6	462	33.0	617	44.1	4.09	1.04
8. I thought that my parents wished I had never been born	1135	81.1	124	8.9	81	5.8	30	2.1	30	2.1	1.35	0.85

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9. I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.	1237	88.4	70	5.0	39	2.8	22	1.6	32	2.3	1.24	0.78
10. There was nothing I wanted to change about my family	290	20.7	204	14.6	373	26.6	213	16.5	302	21.6	3.04	1.42
11. People in my family hit me so hard that it left me with bruises or marks	1173	83.3	89	6.4	69	4.9	41	2.9	28	2.0	1.33	0.86
12. I was punished with a belt, a board, a cord, or some other hard object	886	63.3	218	15.6	208	14.9	52	3.7	36	2.6	1.67	1.03
13. People in my family looked out for each other	42	3.0	53	3.8	126	9.0	386	27.6	793	56.6	4.31	0.99
14. People in my family said hurtful or insulting things to me.	923	65.9	244	17.4	146	10.4	59	4.2	28	2.0	1.59	0.97
15. I believe that I was physically abused.	1133	80.9	119	8.5	78	5.6	48	3.4	22	1.6	1.36	0.86
16. I had the perfect childhood	67	4.8	77	5.5	252	18.0	475	33.9	529	37.8	3.94	1.10
17. I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or doctor.	1245	88.9	76	5.4	46	3.3	19	1.4	14	1.0	1.20	0.65
18. I felt that someone in my family hated me.	958	68.4	191	13.6	137	9.8	72	5.1	42	3.0	1.61	1.05
19. People in my family felt close to each other.	85	6.1	79	5.6	193	13.8	446	31.9	597	42.6	3.99	1.16
20. Someone tried to touch me	1221	87.2	76	5.4	58	4.1	23	1.6	22	1.6	1.25	0.75

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in a sexual way, or tried to make me touch them												
21. Someone threatened to hurt me or tell lies about me unless I did something sexual with them.	1318	94.1	38	2.7	22	1.6	10	0.7	12	0.9	1.11	0.53
22. I had the best family in the World	56	4.0	60	4.3	188	13.4	404	28.9	692	41.4	4.15	1.07
23. Someone tried to make me do sexual things or watch sexual things.	1222	87.3	73	5.2	61	4.4	25	1.8	19	1.4	1.25	0.74
24. Someone molested me.	1309	93.5	30	2.1	29	2.1	8	0.6	24	1.7	1.15	0.64
25. I believe that I was emotionally abused.	718	51.3	213	15.2	216	15.1	148	10.6	105	7.5	2.08	1.33
26. There was someone to take me to the doctor if I needed it	113	8.1	58	4.1	111	7.9	290	20.7	828	59.1	4.19	1.24
27. I believe that I was sexually abused	1305	93.2	30	2.1	32	2.3	12	0.9	21	1.5	1.15	0.64
28. My family was a source of strength and support.	40	2.9	51	3.6	131	9.4	284	20.3	894	63.1	4.39	0.99

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الآثار النفسية و الاجتماعية المترتبة على خبرات سوء المعاملة في مرحلة الطفولة عند طلبة الجامعات الأردنية

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المشرف المشارك
الدكتورة روز قسطنطية

الملخص

إساءة معاملة الأطفال هي مشكلة صحية مدمرة للنفسية الاجتماعية للأفراد والأسر والمجتمع كذلك الأطفال الذين يعانون من سوء معاملة الأطفال معرضين لمخاطر اضطرابات الصحة النفسية. وكان الهدف من هذه الدراسة هو وصف انتشار وأشكال تجربة إساءة معاملة الطفولة بين طلاب الجامعات الأردنية، ودراسة العلاقة بين تجربة سوء المعاملة الطفولة واضطرابات الصحة النفسية، واستكشاف الاختلافات في تجربة إساءة معاملة الطفولة مع المتغيرات الديموقرافية. تم استخدام بيانات جمعت من 1400 طالب من الجامعات الأردنية، وبحثت العلاقة بين تجربة سوء معاملة الطفولة واضطرابات الصحة النفسية.

وجدت علاقة بين خبرة إساءة معاملة الطفولة مع العوامل الديموغرافية والاجتماعية والمتغيرات الشخصية. ودلت النتائج على انا انخفاض دخل الأسرة، والعيش مع شخص آخر ليس من الآباء والأمهات على مخاطر عالية من الاعتداء على الأطفال. وأظهرت نتائج الدراسة ايضا وجود علاقة بين تجربة سوء المعاملة الطفولة واضطرابات الصحة النفسية ، ووجد أيضا علاقة بين شدة تأثير الاعتداء وشدة اضطرابات الصحة النفسية. التحليلات تشير إلى أن الدعم الاجتماعي يمكن أن يلعب دور الوسيط في تلطيف الآثار المترتبة على الاعتداء على الطفولة واضطرابات الصحة النفسية.

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